

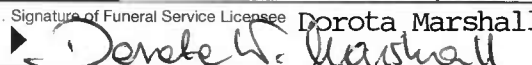
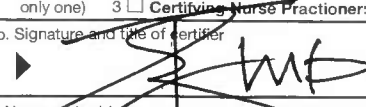

1- For State Registrar

Certificate of Death

Reg. No. 2011 05501  
 Date of Death February 22, 2011  
 Time of Death 4:44 PM  
 4:45pm

Physician/  
Medical  
Examiner

Funeral  
Director

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Waltraud Anna Futran</b>  |  | 2. Date of Death<br><b>February 22, 2011</b>   |  | 3. Time of Death<br><b>4:44 PM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>907 Parade Lane</b>   |  | 4b. City, Town, or Location of Death<br><b>Mount Airy</b>  |  | 4c. County of Death<br><b>Frederick Carroll</b>  |  |
| 5. Social Security Number<br><b>101-26-0948</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>09/16/1929</b>   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Frederick Carroll</b>  | 10c. City, Town or Location<br><b>Mount Airy</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>907 Parade Lane</b>   |  | 10f. Zip Code<br><b>21771</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>Own Home</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilhelm Bauerlein</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susanna Edelmann</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan Futran / Daughter</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>331 W. Main Street, Sharpsburg, MD 21782</b> |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Final Journey crem.</b>   |  | 20c. Location - City or Town, State<br><b>Woodbine, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Maryland Cremation Services<br/>PO Box 1413, Baltimore, MD 21203</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dehydration</b><br>a. Due to (or as a consequence of):<br><b>Organic Brain Syndrome</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |  |  |  |  |
| Approximate Interval Between Onset and Death   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
| 29b. Signature and Title of Certifier<br>   |  | 29c. License number<br><b>D 35370</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 23, 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jan Bachowski, MD 11125 Rockville Pike, Rockville, MD 20852</b>   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05502

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Clyde Earnest Foster, Sr.

2. Date of Death

02/15/2011 Year

3. Time of Death

4:00p M

4a. Facility Name (If not institution, give street and number)

7701 Oakwood Road Apt 101

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

235-20-2756

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

75 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

11/30/1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7701 Oakwood Road, Apt. 101

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Maint. Supervisor

16b. Kind of Business Industry

Hospital

17. Father's Name (First, Middle, Last)

William Ray Foster, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Catherine A. McConnell

19a. Informant's Name/Relationship (Type, Print)

Betty Lee Foster / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Light Street Avenue, Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Baltimore National

Date

2/18/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 39166

29d. Date signed (Month, Day, Year)

02/16/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALVIN S. MADARANG, MD 808 LANDMARK DR STE 128 GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



amend #1, per Phy, g927 5-29-12 sm  
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8 per FH, G912 2/24/2011, WS  
State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEM#1 per PHYS, G927 5/21/2012, WS  
Certificate of Death

Reg. No.

2011 05503

1- For State Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>AVELINA LAZO GONZALEZ</b>   |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>30</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>5:50 A M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>SACRED HEART NURSING HOME</b>   |  | 4b. City, Town, or Location of Death<br><b>HYATTSVILLE</b>  |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |  |
| 5. Social Security Number<br><b>577-08-4360</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   |  |
| 8. Date of Birth<br><b>Nov. 10, 1917</b><br>(Month, Day, Year)   |  | 9. Birthplace (State or Foreign Country)<br><b>ELSALVADOR</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>HYATTSVILLE</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>5805 QUEENS CHAPEL ROAD</b>   |  | 10f. Zip Code<br><b>20782</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>HISPANIC</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b><br>College (1-4 or 5+) <b>HOUSEWIFE</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  | 16b. Kind of Business Industry<br><b>PRIVATE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>AUGUSTINE LAZO-CRUZ</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSA LAZO-CRUZ</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EDIS GONZALEZ/DGT.</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6707 ASSETT DRIVE HYATTSVILLE, MARYLAND 20785</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RIVERDALE CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>2/7/2011 RIVERDALE, MARYLAND</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>J.B. JENKINS FUNERAL HOME, INC.<br/>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b><br>Due to (or as a consequence of):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  | Approximate Interval Between Onset and Death |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>g <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D51051</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 3, 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANDRES SALAZAR M.D. 3621 LIGON ROAD ELLICOTT CITY, MARYLAND 21042</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2011 05504

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilbert M. Graybeal

2. Date of Death

February 23 2011

3. Time of Death

4:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Lorien of Bel Air

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

219-30-4492

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 13, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1205 Bonaire Road

10f. Zip Code

21050

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Motel

17. Father's Name (First, Middle, Last)

Miller C. Graybeal

18. Mother's Name (First, Middle, Maiden Surname)

Ida D. Boyer

19a. Informant's Name/Relationship (Type, Print)

Carolyn Crawford Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1205 Bonaire Road Forest Hill, Maryland 21050

20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

2-24-2011

20c. Location - City or Town, State

Towson Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA, ENDSTAGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ATRIAL FIBRILLATION,

PULMONARY FIBROSIS, B-12 DEFICIENCY

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

LIVING

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X

29b. Signature and title of certifier

[Signature] MD

29c. License number

D45344

29d. Date signed (Month, Day, Year)

02/23/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH DHANTANI, MD, 622 S. UNION AVE, HARRE DE GRACE, MD 21078

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, WILBERT GRAYBEAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05505

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HATTIE GORHAM

2. Date of Death

February 15 2011

3. Time of Death

8:30 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard County

5. Social Security Number

246-30-3994

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan 9, 1924

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Willicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3000 N. Ridge Rd.

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

housewife

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Moran Sylvester - stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

722 Allendale St; Baltimore, MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify)

in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Home Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board

655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. *Staphylococcus sepsis*

Due to (or as a consequence of):

b. *Aspiration pneumonia*

Due to (or as a consequence of):

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

Approximate

Interval Between

Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

M

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check

only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Raw

29c. License number

P30641

29d. Date signed (Month, Day, Year)

February 15 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramon Sabapalan 201-109 Back River Neck Road Baltimore MD

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Ramon S. Sabapalan

2/22/11

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05506

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Margaret Greene

2. Date of Death

February 22 2011

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

Pineview Future Care

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

572-28-7090

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/30/1924

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9106 Pine View Lane

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unkn.

16b. Kind of Business/Industry

unkn.

17. Father's Name (First, Middle, Last)

James Edward Butler

18. Mother's Name (First, Middle, Maiden Surname)

Mae Waddy

19a. Informant's Name/Relationship (Type, Print)

Sheila A. Perez / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9800 Caltor Lane, Fort Washington, MD

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Final Journey Crem.

Date

2/25/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Dorota Marshall

22. Name and Address of Facility

Maryland Cremation Services

PO Box 1413, Baltimore, MD 21203

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Vascular Dementia  
Due to (or as a consequence of):b. Cerebrovascular Disease  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiovascular Disease

Insulin dependant Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Pending  
investigation 3 ☐ Accident  
4 ☐ Suicide 5 ☐ Could not be  
determined 6 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dorothy Seay

29c. License number

P0053337

29d. Date signed (Month, Day, Year)

February 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy Seay 2835 Smith Avenue Ste 203 Baltimore, Md 21209

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Sandra A. Spivey

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05507

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Herta

Griskenas

2. Date of Death

Feb. 20, 2011

3. Time of Death

11:30 am

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Ridgeway Manor

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

217-32-9597

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

Jan. 1, 1927

9. Birthplace (State or Foreign Country)

Lithuania

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1725 Letitia Ave.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Julius Frenkelyte

18. Mother's Name (First, Middle, Maiden Surname)

Julia (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Rose Griskenas (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1725 Letitia Ave., Baltimore, MD 21230

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory @ Loudon Park

Date

2/24/11

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loudon Park Funeral Home

3620 Wilkens Ave., Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Breast Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Several months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depression, Dementia, COPD, Hypertension, Osteoporosis, Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Geetha Raja MD

29c. License number

D27541

29d. Date signed (Month, Day, Year)

February 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEETHA RAJA MD, 4367 Hollins Ferry Rd, Baltimore, MD 21227

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

John B. Gove

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 2011 05508

Physician/  
Medical Examiner  
  
  
Funeral  
Director

17893  
Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 1. For State Registrar   |  | 2. Date of Death<br>Month Day Year<br>February 2, 2011   |  | 3. Time of Death<br>1751 hrs  |   |
| 1. Decedent's Name (First, Middle, Last)<br>John Wesley Griggs   |  |  |  |   |   |
| 4a. Facility Name (if not institution, give street and number)<br>11 W. Baltimore Street Apt. # 321  |  |  | 4b. City, Town, or Location of Death<br>Hagerstown   |   | 4c. County of Death<br>Washington   |
| 5. Social Security Number<br>146-53-4892   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>49 Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br>6-13-1961  | 9. Birthplace (State or Foreign Country)<br>GA  |
| Usual Residence of Decedent  |  |  |  |   |   |
| 10a. State<br>MD   |  | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Hagerstown   |   |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |   |
| 10e. Street and Number<br>11 W. Baltimore Street   |  |  | 10f. Zip Code<br>21740   |   | 10g. Citizen of What Country?<br>USA  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th grade<br>College (1-4 or 5+) College (1-4 or 5+)   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                  |   | 16b. Kind of Business/Industry<br>unk   |
| 17. Father's Name (First, Middle, Last)<br>Jimmy Prather   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Macie Ann Griggs  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Tena Griggs-Wife   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1432 W. State Street Trenton, n. J. 08618 |   |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lansdale Crematory   |  | 20c. Location - City or Town, State<br>Lansdale, PA   |   |
| 21. Signature of Funeral Service Licensee<br><i>Agnette K. Jones</i>   |  | 22. Name and Address of Facility<br>Dickerson Funeral Chapel<br>32 Arctic Parway Ewing, N. J. 08638  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cocaine and morphine intoxication<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #23a, 27, 28a-f, per ME, G913, 3/2/2011, WS |  |  |  |   | Approximate Interval Between Onset and Death  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |  |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |   |   |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>found 2-2-11   |  | 28b. Time of Injury<br>found 5:48pm   |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>unknown   |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>found at home  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>11 W. Baltimore St Apt. #321 Hagerstown, Maryland  |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |
| 29b. Signature and title of certifier<br><i>Patricia Aronica-Pollak</i><br>Patricia Aronica-Pollak MD. Assistant Medical Examiner  |  |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>February 3, 2011   |
| 30. Name and address of person who completed cause of death (Item 23a)<br>Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br>FEB 24 2011   |  | 32. Registrar's Signature<br><i>James B. Davis</i>   |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05509

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cheryl

2. Date of Death

February 19 2011

3. Time of Death

10:10 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

212-70-6716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/03/1957

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore, City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2132 Orleans Street

10f. Zip-Code

21231

10g. Citizen of What Country?

MD

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Caruthers Gant Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Williams

19a. Informant's Name/Relationship (Type, Print)

Tennille Gant / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2132 Orleans St. Balto. MD 21231

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARDENT CREM

Date

2/26/2011

20c. Location - City or Town, State

HAIWATER MD

21. Signature of Funeral Service Licensee

Phillip A Weatherford FS

22. Name and Address of Facility

2431 E. Oliver St. Balto. MD 21213

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

b. Gastrointestinal obstruction

Due to (or as a consequence of):

c. Advanced ovarian cancer

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of certifier

Phillip A Weatherford FS

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 19, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKEY IBEANU

600 North Wolfe St, Baltimore, MD, 21287

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Senior A. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05510

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Velma Grant

2. Date of Death

Feb. 20 2011 0900 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Genesis Cromwell

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-07-5631

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jun. 13, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2 POMONA WEST, #1

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL

18. Mother's Name (First, Middle, Maiden Surname)

SNYDER

ETHEL

SNYDER

19a. Informant's Name/Relationship (Type, Print)

JANET DAVID / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3608 WOODVALLEY DRIVE, BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of Institution, Cemetery, etc.)

CHIZUK AMUNO CONG.

Date

02/23/2011

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiovascular disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

R086520

29d. Date signed (Month, Day, Year)

February 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen Jennings 6055 Marshall Drive Elkridge, Md. 21045

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05511

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John S. Gregory

2. Date of Death

February 23, 2011

3. Time of Death

1:30 a M

4a. Facility Name (If not institution, give street and number)

18 Windward Way

4b. City, Town, or Location of Death

Middle River

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-28-2055

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

8. Date of Birth (Month, Day, Year)

December 27, 1929

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

18 Windward Way

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

John S. Gregory

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Schuster

19a. Informant's Name/Relationship (Type, Print)

Lois J. Gregory Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Windward Way, Middle River, Md 21220

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

February 23, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensed



22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

End stage dementia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death☐ Pregnant at time of death☐ Unknown☐ Ectopic pregnancy☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism. pneumonia.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D69540

29d. Date signed (Month, Day, Year)

2/23/2011.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tigay Shah, 8813 Walkman Woods Rd suite 204 Parkville MD 21236.

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05512

1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Christopher David Hoyt

2. Date of Death  
Month Day Year  
February 16, 20113. Time of Death  
0035 hrs4a. Facility Name (if not institution, give street and number)  
980 Mercantile Lane4b. City, Town, or Location of Death  
Hanover4c. County of Death  
Anne Arundel5. Social Security Number  
529-59-59276. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
30 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
2/19/809. Birthplace (State or Foreign Country)  
UT

Usual Residence of Decedent

10a. State  
MD10b. County  
Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No10e. Street and Number  
1265 Vogt Avenue, Apt A10f. Zip Code  
2122710g. Citizen of What Country?  
USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:  
US Army13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No specify:14. Race - American Indian, Black,  
White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Sunbelt Rentals

17. Father's Name (First, Middle, Last)  
Robert Lee Hoyt18. Mother's Name (First, Middle, Maiden Surname)  
Diane Short

19a. Informant's Name/Relationship (Type, Print)

Robert Hoyt / Father  
Erica Marie Hoyt / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6358 W. 43 Squanto Ct. Middle River, MD 21220

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:20b. Place of Disposition (Name of cemetery,  
crematory or other place)

Gardner Crematory

Date

2/23/11

20c. Location - City or Town, State

Salt Lake City, UT

21. Signature of Funeral Service Licensee Victor P. Doda

22. Name and Address of Facility

Charles L. Stevens Funeral Hoem, Inc.  
1501 East Fort Avenue, Baltimore MD 21220

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Shotgun Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☒ AMENDED

#19a.b.perFH.G912.2/24/2011.WS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)  
Feb 16, 201128b. Time of Injury  
0035 hrs28c. Injury at Work?  
1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office building, etc.  
(Specify) Parking Lot28d. Describe how injury occurred  
Subject shot self28f. Location (Street and Number or Rural Route Number, City or Town, State)  
980 Mercantile Lane, Arbutus, Md29a. Certifier (Check only one)  
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 16, 2011

30. Name and address of person who completed cause of death (Item 23a)  
Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31. Date filed (Month, Day, Year)  
FEB 24 2011

Registrar's Signature

Zabiullah Ali

ORIGINAL

OCME

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05514

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Charles Haigis

2. Date of Death

Feb 19 2011

3. Time of Death

23:55 M

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

219-14-1373

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs, last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov 9, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

312 Dogwood Road

10f. Zip Code

21108

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No 1943-  
If Yes, Give Year or Dates. 194613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

truck driver

16b. Kind of Business Industry

transportation

17. Father's Name (First, Middle, Last)

Rudolph Haigis

18. Mother's Name (First, Middle, Maiden Surname)

Mary Margaret Smith

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Haigis - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Dogwood Rd; Millersville, Maryland 21108

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board

655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

Hypovolemic shock

Massive upper GI bleed

Approximate  
Interval Between  
Onset and Death

2 hrs

5 hrs

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe cardiomyopathy  
ESRD - DD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Therese Goring MD

29c. License number

D0056571

29d. Date signed (Month, Day, Year)

Feb 20, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kore Goring MD; Anne Arundel Medical Center

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

James S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

**To Be Completed by Funeral Director**

**Medical Certificate: To Be Completed by Physician/Medical Examiner**

1- For State Registrar

Certificate of Death

Reg. No. 2011 05516

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Johnnie Isabell **Johnnie Isabell** 2. Date of Death Month 01 Day 27 Year 11 3. Time of Death 6:15AM M

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Future Care - Sandtown 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore  
5. Social Security Number 229-24-4980 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) 75 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Sept 8, 1935 9. Birthplace (State or Foreign Country) Virginia

Usual Residence of Decedent 10a. State MD 10b. County Baltimore 10c. City, Town or Location Baltimore 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 757 Edgewood St. 10f. Zip Code 21229 10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) truck driver 16b. Kind of Business Industry Sherwin Williams

17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk

19a. Informant's Name/Relationship (Type, Print) Michael Moore - son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2828 Potee St; Baltimore, MD 21225

20a. Method of Disposition ☐ Burial ☐ Cremation ☐ Removal from State ☒ Donation ☒ Other (Specify) in state 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiomyo Pathy Due to (or as a consequence of): b. Chronic Kidney dz Due to (or as a consequence of): c. Pleural effusion Due to (or as a consequence of): d. Failure To Thrive Approximately Interval Between Onset and Death

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☐ No ☒ Unknown 23c. If yes, outcome of pregnancy ☐ Live Birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify) 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] 29c. License number D0065383 29d. Date signed (Month, Day, Year) 02-17-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shabbir Choudhary 5415 Oldcourt Road Suite #101 Randallstown MD 21133

31. Date filed (Month, Day, Year) FEB 24 2011 32. Registrar's Signature [Signature]

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05517

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERONICA MONICA ORBIN JAMES

2. Date of Death

FEBRUARY 18, 2011

3. Time of Death

6:10 A M

4a. Facility Name (if not institution, give street and number)

FRANKLIN WOODS NURSING HOME

4b. City, Town, or Location of Death

ROSEDALE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

236-36-1566

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-13-1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2030 FLINTSHIRE ROAD

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DIETARY

16b. Kind of Business Industry

MERCY HOSPITAL

17. Father's Name (First, Middle, Last)

ANTHONY

ORBIN

18. Mother's Name (First, Middle, Maiden Surname)

JULIA

( PLATT )

19a. Informant's Name/Relationship (Type, Print)

MARCELLA J. MAGSAMEN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

228 ELINOR AVENUE BALTIMORE, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

DULANEY VALLEY MEM 2-22-11

Date

20c. Location - City or Town, State

TIMONIUM, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME  
1211 CHESACO AVE ROSEDALE, MD 21237Physician/  
Medical  
Examiner23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate  
Interval Between  
Onset and Death

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Clostridium difficile colitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

#35593

29d. Date signed (Month, Day, Year)

2/18/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PR. John Lok 1124 Race Ave, Balto, MD, 21221

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05518

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELLEN JUSTIS

2. Date of Death

FEB 21 2011

3. Time of Death

12 05 PM

4a. Facility Name (if not institution, give street and number)

Enclave at Turf Valley

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

216-16-2992

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

8. Date of Birth

5-27-1920

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

VA

10b. County

Accomac

10c. City, Town or Location

Parksley

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

27282 Whiteneck Road

10f. Zip Code

23421

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Entrepreneur

16b. Kind of Business Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Thomas Cutler

18. Mother's Name (First, Middle, Maiden Surname)

Zennie Young

19a. Informant's Name/Relationship (Type, Print)

Romona Gatewood/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4815 Coyle Rd., Apt. 203, Owings Mills, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wharton Cemetery

Date

2-27-2011

20c. Location - City or Town, State

Parksley, VA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Wyllie Funeral Home P.A. of Balto. Co.

9200 Liberty Road, Randallstown, MD 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. A V BLOCK (A TRIO VENTRICULAR BLOCK)

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ATHEROSCLEROSIS

Due to (or as a consequence of):

months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage dementia → months  
dysphagia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0053150

29d. Date signed (Month, Day, Year)

FEB 22 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAWNMAA GUPTA, 9650 SANTIAGO RD

SUITE 110

COLUMBIA

MD 21045

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05519

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Thomas Johnston Sr.

2. Date of Death

February 18 2011

3. Time of Death

1534 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital @ Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

212-82-5153

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 8, 1960

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7166 Lauren Lane; Apt 1405

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

technician

16b. Kind of Business Industry

swimming pools

17. Father's Name (First, Middle, Last)

Paul Leroy Johnston

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Nanette Cullen

19a. Informant's Name/Relationship (Type, Print)

Lisa Wielgosz - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 N. Maple Ave; Ridgely, Maryland 21660

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard S. Wade, Director

22. Name and Address of Facility

State Anatomy Board

655 W. Baltimore St; Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. colon cancer, metastatic

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sepsis syndrome

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul W. Monte, MD

29c. License number

64043

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul W. Monte, MD 219 S. Washington St. EASTON, MD 21601

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Susan B. Spaw

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05520

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Everett Johns

2. Date of Death

Feb 21 2011

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Season's Hospice

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

219-18-7792

6. Sex

X ☐ M ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

8. Date of Birth

02 24 24

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 Durum Ct.

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

3yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Lab. Tech.

16b. Kind of Business Industry

Fort Detrick

17. Father's Name (First, Middle, Last)

Robert Lee Johns Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Goldie Wilson

19a. Informant's Name/Relationship (Type, Print)

Joni Williams-Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Durum Ct., Owings Mills, Md 21117

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

On-Site

Date

2/23/2011

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral thrombosis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D15872

29d. Date signed (Month, Day, Year)

Feb 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moran Bob 6934 Aquadun Blvd Suite N 21061

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #17&18 Per FH G913 3/07/2011 JH  
State of Maryland Department of Health and Mental Hygiene1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2011 05521

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fr. Callistus Juras

2. Date of Death

Month February Day 15 Year 2011

3. Time of Death

6:30 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

Baltimore

5. Social Security Number

047-58-2855

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 14, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Franciscan Friar/Priest

16b. Kind of Business Industry

Teacher &amp; Pastor

17. Father's Name (First, Middle, Last)

Mary Juras Mark Charles Juras

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Janka Irene Janka

19a. Informant's Name/Relationship (Type, Print)

Rev. Richard Forcier

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21042  
12300 Folly Quarter Road Ellicott, City, Md

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify)

Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cem.

February

18, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert Scott Brannan

22. Name and Address of Facility

Kaczorowski Funeral Home, P.A.  
1201 Dundalk Avenue Baltimore, Md. 21222Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Severe Chronic Obstructive Pulmonary Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DCA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Scott Brannan M.D.

29c. License number

BB9122792

29d. Date signed (Month, Day, Year)

2/15/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Scott Brannan M.D 7601 Oster Drive Towson, MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Dawn A. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5 per FH G912 2/24/2011 WS  
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05522

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Kane

2. Date of Death

Month Day Year  
Feb 9, 2011

3. Time of Death

1:40 AM

4a. Facility Name (If not institution, give street and number)

Severna Park Center

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

006-06-0811

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
5-3-1924

9. Birthplace (State or Foreign Country)

MAINE

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1942 Hilltop Road

10f. Zip Code

20794

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Pharmaceutical Sales Rep.

16b. Kind of Business/Industry

Pharmaceutical

17. Father's Name (First, Middle, Last)

Martin John Kane

18. Mother's Name (First, Middle, Maiden Surname)

Delia E. Curran

19a. Informant's Name/Relationship (Type, Print)

Maurcen Smith - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1942 Hilltop Road Jessup, Md 20794

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Calvary Cemetery

Date

2/15/2011

20c. Location - City or Town, State

South Portland, Maine

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Charles L. Stevens F.H. INC.  
1501 E. Fort Avenue Balto Md 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. advanced dementia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D50725

29d. Date signed (Month, Day, Year)

2-10-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger 8601 Veterans Hwy M. Uersville MD 21088

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05523

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Josephine M. Kirwin

2. Date of Death

February 23 2011

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

Manor Care- Ruxton

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

197-03-0027

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth (Month, Day, Year)

11-19-1920

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1224 Charmuth Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Florintino

Viola

18. Mother's Name (First, Middle, Maiden Surname)

Concetta

Tramenda

19a. Informant's Name/Relationship (Type, Print)

Concetta Kirwin Lew Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1224 Charmuth Road Lutherville, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Sepulchre Cem.

Date

2-28-2011

20c. Location - City or Town, State

Wyndmoor, PA

21. Signature of Funeral Service Licensee

Frank Hagan

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary disease

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard O. Addo, M.D., Attending

29c. License number

D0059283

29d. Date signed (Month, Day, Year)

February 23, 2011

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

Richard O. Addo, M.D., 8415 Bellona Lane, Towson, MD 21204

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Kenna B. Spivey

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, &amp;

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 05524

1- For State Registrar

1. Decedent's Name (First, Middle, Last)

Kathi Knecht

2. Date of Death

Month Day Year  
January 27, 2011

3. Time of Death

1102 hrs

4a. Facility Name (if not institution, give street and number)

705 Baker Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

unk

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53

8. Date of Birth (MM/DD/YYYY)

Nov 26, 1957

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

705 Baker St.

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

unk

1 ☐ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Joseph Plummer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unk

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

4 ☐ Donation 5 ☒ Other Specify: in state

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board

655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED

☐ AMENDED 23a,pt.II,27 per me g913 3-1-11 vt

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Enterogenital Fistula

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation

2 ☐ Accident

3 ☐ Suicide 6 ☐ Could not be determined

4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 28, 2011

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

*[Signature]*

17894  
Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05525

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clare Elizabeth Kinol

2. Date of Death

February 11, 2011

3. Time of Death

12:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

45706 Locust Glen Court

4b. City, Town, or Location of Death

Grat Mills

4c. County of Death

St. Marys

5. Social Security Number

179-38-2320

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 1, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Saint Marys

10c. City, Town or Location

Great Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

45706 Locust Glen Court

10f. Zip Code

20634

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Charles Karalfa

18. Mother's Name (First, Middle, Maiden Surname)

Mary Luther

19a. Informant's Name/Relationship (Type, Print)

Susan Leonard - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45706 Locust Glen Ct; Great Mills, MD 20634

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility State Anatomy Board

655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Coronary Heart Disease

Due to (or as a consequence of):

b.

Hypertension

Due to (or as a consequence of):

c.

Sickle Cell Anemia

Due to (or as a consequence of):

d.

Anemia

Approximate Interval Between Onset and Death

4 hrs

25 yrs

25 yrs

?

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old age  
Acute Myocardial Infarction 1-9-11

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael S. Szpotnicki

29c. License number

D31952

29d. Date signed (Month, Day, Year)

2-16-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL S. SZPOTNICKI

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Ronald S. Wade

State  
Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05526

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Diane King - Bauer

2. Date of Death

February 16, 2011

3. Time of Death

3:36 p M

4a. Facility Name (if not institution, give street and number)

Upper Chesapeake Medical Center

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-52-5318

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

65

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/4/1945

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

702 West Mac Phail Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

own Home

17. Father's Name (First, Middle, Last)

Leonard Albrecht

18. Mother's Name (First, Middle, Maiden Surname)

unkn.

19a. Informant's Name/Relationship (Type, Print)

Richard Wentworth Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6700 Beech Avenue, Baltimore, MD 21206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Final Journey crem.

Date

2/22/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Quanta R. Thomas

22. Name and Address of Facility

Maryland Cremation Services  
PO Box 1413, Baltimore, MD 21203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Anoxic encephalopathy

b. Due to (or as a consequence of):

cardiac arrest

c. Due to (or as a consequence of):

Ventricular fibrillation

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sid Z. Kharal

29c. License number

D63420

29d. Date signed (Month, Day, Year)

February 16, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sid Z. Kharal 500 Upper Chesapeake Drive Bel Air, MD 21014

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Annmarie A. Powell

ORIGINAL

DOO 2/16/11 7:10 1536  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

M800466197 King, Diane  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 10e, 20b, per PH, C912, 2/24/2011, WS  
State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Certificate of Death

Reg. No.

2011 05527

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Merritt V. Kaintuck Sr

2. Date of Death

2 22 11

3. Time of Death

0205A

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Good Samaritan

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

216-28-0069

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

8. Date of Birth

12/02/1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5908 Northwood Road Drive

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Samuel Kaintuck

18. Mother's Name (First, Middle, Maiden Surname)

Estella Greene

19a. Informant's Name/Relationship (Type, Print)

Mary A. Kaintuck

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Wife 5908 Northwood Drive Baltimore, Maryland 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount

Date

3/5/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Baughn C. Greene F.S. 4905 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atrio-Ventricular Block

Approximate Interval Between Onset and Death

5 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Ischemia

10 hrs

c. Coronary Atherosclerosis

years

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be determined  
4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature], M.D.

29c. License number

00042083

29d. Date signed (Month, Day, Year)

2-28-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greta A. Wheeler Good Samaritan Hospital Emergency Department

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



1- For State Registrar

Certificate of Death

Reg. No.

|   |   |  |   |  |   |   |   |  |
|---|---|--|---|--|---|---|---|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HAYIM KUTZER</b>   |  |   |  | 2. Date of Death<br>Month <b>02</b> Day <b>21</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>12:50 P M</b>                                    |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>LEVINDALE HEBREW HOME</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-18-6137</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>92</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>12/24/1918</b>                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>POLAND</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>6210 PARK HEIGHTS AVENUE, 802</b>  |  | 10f. Zip Code<br><b>21215</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROPRIETOR</b>                        |  | 16b. Kind of Business Industry<br><b>OFFICE SUPPLIES</b>  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH KUTZER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CHAI ZELTZER</b>  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>NEIL GOLDBERG / cousin</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>347 WEST 57TH STREET, #43B, NEW YORK, NY 10019</b>  |   |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH TFILOH CONG.</b>  |  | 20c. Date<br><b>02/23/2011</b>  |   | 20d. Location - City or Town, State<br><b>WOODLAWN, MD</b>              |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>  |   |   |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>COMPLICATIONS OF DEMENTIA</b>  |  |   |  |   |   |   |  |
|   | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>PNEUMONIA</b> |  |   |  |   |   |   |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  |   |  | 23d. Date of delivery<br>Month Day Year   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day, Year) |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
| 28d. Describe how injury occurred   |   |  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>PHYSICIAN</b>   |   |  |   | 29c. License number<br><b>00064533</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>02/21/2011</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LEVINDALE GERIATRIC CTR AND HOSPITAL 2434 W. BELVEDERE AVENUE BALTIMORE, MD</b>  |   |  |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |   |  |   | 32. Registrar's Signature<br>  |   |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bai Rong Li

2. Date of Death

February 20, 2011

3. Time of Death

10:50 a.m.

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Summit Park Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

219-45-9775

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 20, 1923

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4615 Wilkens Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Management

16b. Kind of Business Industry

Chinese Government

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

James J. Rossi/Son-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4615 Wilkens Ave., Baltimore, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

2-26-2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Ambrose Funeral Home, Inc  
1328 Sulphur Spring Rd., Arbutus, MD 21227

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

pneumonia fatal

b. Due to (or as a consequence of):

atherosclerotic disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks  
(10 yrs)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Sandra S. Sparks

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John James Lambros

2. Date of Death

February 21, 2011

3. Time of Death

6:50 A M

4a. Facility Name (if not institution, give street and number)

The Maples

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-12-7901

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 14, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Ruxton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Ruxton Hill Road

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Asst. General Manager

16b. Kind of Business Industry

Bethlehem Steel  
Corporation

17. Father's Name (First, Middle, Last)

James John Lambros

18. Mother's Name (First, Middle, Maiden Surname)

Vasiliki Pertessis

19a. Informant's Name/Relationship (Type, Print)

Valerie Lambros Heneberry/dtr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Shady Brook Court; Lutherville, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greek Orthodox Cem.

Date

2/24/2011

20c. Location - City or Town, State

Woodlawn, MD

21. Signature of Funeral Service Licensee

Amy N. Silvestri

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc. 1050 York Road  
Towson, MD 2120423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Severe Anemia

Due to (or as a consequence of):

b. GI Bleeding (Lower)

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Few days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Dementia  
Type II DM

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) ALF

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A22

29c. License number

A0061485

29d. Date signed (Month, Day, Year)

2/23/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bushra I. AL-Azzawi, MD, Suite 301, 9103 Franklin Sq. Dr. Axxdale, MD 21237

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Amy N. Silvestri

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Charles Arthur Larson, Jr.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 05531

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

|  |  |  |  |                              |
|--|--|--|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br>Charles Arthur Larson, Jr. |  | 2. Date of Death<br>Month Day Year<br>January 30, 2011 |  | 3. Time of Death<br>1655 hrs |
|--|--|--|--|------------------------------|

Funeral  
Director

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 4a. Facility Name (if not institution, give street and number)<br>9 East Eager Street |  | 4b. City, Town, or Location of Death<br>Baltimore |   | 4c. County of Death                          |   |
| 5. Social Security Number<br>unk  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>61 Yrs.         | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>May 1, 1949 | 9. Birthplace (State or Foreign Country)<br>unk |

|                             |             |  |  |
|-----------------------------|-------------|--|--|
| Usual Residence of Decedent |             |  |  |
| 10a. State<br>MD            | 10b. County | 10c. City, Town or Location<br>Baltimore | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |

|   |  |                        |                                      |
|---|--|------------------------|--------------------------------------|
| 10e. Street and Number<br>9 E. Eager Street |  | 10f. Zip Code<br>21202 | 10g. Citizen of What Country?<br>USA |
|---|--|------------------------|--------------------------------------|

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |
|---|--|--|--|--|--|--|--|

|   |  |  |  |                                       |  |
|---|--|--|--|---------------------------------------|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) unk<br>College (1-4 or 5+) unk |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>unk |  | 16b. Kind of Business/Industry<br>unk |  |
|---|--|--|--|---------------------------------------|--|

|   |  |   |  |
|---|--|---|--|
| 17. Father's Name (First, Middle, Last) unk |  | 18. Mother's Name (First, Middle, Maiden Surname) unk |  |
|---|--|---|--|

|  |  |   |  |
|--|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Martha Larson - stepmother |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk |  |
|--|--|---|--|

|   |  |  |  |                                     |  |
|---|--|--|--|-------------------------------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify: in state |  | 20b. Place of Disposition (Name of cemetery, crematory or other place) |  | 20c. Location - City or Town, State |  |
|---|--|--|--|-------------------------------------|--|

|   |  |   |  |
|---|--|---|--|
| 21. Signature of Funeral Service Licensee<br> |  | 22. Name and Address of Facility<br>State Anatomy Board<br>655 W. Baltimore St; Baltimore, MD 21202 |  |
|---|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  | Approximate Interval Between Onset and Death |  |
|---|--|--|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
|--|--|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |
|---|--|--|--|

|   |  |  |  |                     |  |  |  |                                   |  |
|---|--|--|--|---------------------|--|--|--|-----------------------------------|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |                                   |  |

|  |  |                                 |  |   |  |
|--|--|---------------------------------|--|---|--|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. License number<br>O.C.M.E. |  | 29d. Date signed (Month, Day, Year)<br>January 31, 2011 |  |
|--|--|---------------------------------|--|---|--|

|   |  |                                 |  |   |  |
|---|--|---------------------------------|--|---|--|
| 29b. Signature and title of certifier<br> |  | 29c. License number<br>O.C.M.E. |  | 29d. Date signed (Month, Day, Year)<br>January 31, 2011 |  |
|---|--|---------------------------------|--|---|--|

|   |  |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |  |
|---|--|

|  |  |                               |  |
|--|--|-------------------------------|--|
| 31. Date filed (Month, Day, Year)<br>FEB 24 2011 |  | 32. Registrar's Signature<br> |  |
|--|--|-------------------------------|--|

State  
Registrar

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05532

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

William Rudolph Lake

2. Date of Death  
Month Day Year

February 14, 2011

3. Time of Death

8:59 A M

4a. Facility Name (If not institution, give street and number)

6063-1 Majors Lane

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

421-28-8132

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

8. Date of Birth (Month, Day, Year)

March 8, 1927

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6063-1 Majors Lane

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1946-

If Yes, Give Year or Dates: 1948

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

computer supervisor

16b. Kind of Business/Industry

FBI/NIH

17. Father's Name (First, Middle, Last)

Marvin L. Lake

18. Mother's Name (First, Middle, Maiden Surname)

Anna Janie Barton

19a. Informant's Name/Relationship (Type, Print)

Mary A. Lake - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6063-1 Majors Lane; Columbia, Maryland 21045

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board  
655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

6 weeks

Sequentially list conditions, if any, leading to immediate cause.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Geller M.D.

29c. License number

d34613

29d. Date signed (Month, Day, Year)

Feb 17, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Geller M.D. 8186 Lark Brown Rd Ellicott City MD 21042

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's signature

Ronald S. Wade

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05533

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry C Luck Sr.

2. Date of Death  
Month Day Year  
February 19, 20113. Time of Death  
17:03 M

4a. Facility Name (if not institution, give street and number)

1326 Washington Drive

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

215-48-1487

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/13/1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1326 Washington Drive

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Food Inspector

16b. Kind of Business Industry

State of MD

17. Father's Name (First, Middle, Last)

Jerry C. Luck M.D.

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Carlock

19a. Informant's Name/Relationship (Type, Print)

Mr. Larry Luck, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

35 Bates Street Washington, DC 20001

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Atlantic Crematory

Date

2/26/2011

20c. Location - City or Town, State

Glen Burnie, MD 21061

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Singleton Funeral & Cremation  
Services, PA 1 2nd Ave SW Glen Burnie, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Angiocardiores.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

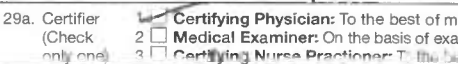
(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)29b. Signature and title of certifier  
  
29c. License number  
D 36761  
29d. Date signed (Month, Day, Year)  
2/21/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Riedman 129 Lubranl Road Ste.100 Annapolis Maryland 21401

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

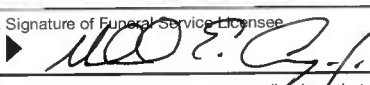
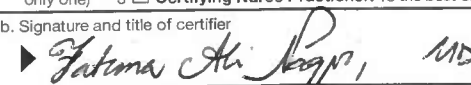

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit



1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |   |  |  |  |
|---|---|--|---|--|--|--|--|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Marie Elizabeth Lerch</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>February 22, 2011</b>   |  |  |  | 3. Time of Death<br><b>03:15 A M</b>  |  |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Lorien Health Care</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  |  |  | 4c. County of Death<br><b>Howard Co.</b>  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-14-0807</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>03/07/1919</b>                             |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel Co.</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   | 10e. Street and Number<br><b>510 Marion Road</b>  |  |   |  | 10f. Zip Code<br><b>21061</b>  |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business Industry<br><b>Own Home</b>                                    |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>William Joseph Murphy</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mae Elizabeth Pilkerton</b>  |  |  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Mary Anne Lerch / Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18 Falcon Crest Drive Harbeson, DE 19951</b>   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>   |  | Date<br><b>2/24/2011</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b>                        |  |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Singleton Funeral &amp; Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061</b>   |  | M01121   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASPIRATION PNEUMONIA</b>  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>DAY → HOURS</b>  |  |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>Due to (or as a consequence of):<br><b>DYSPHAGIA</b><br>Due to (or as a consequence of):<br><b>DEMENTIA, (SEVERE VASCULAR DEMENTIA)</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):        |  |   |  |  |  |  |  | <b>MONTHS → YEARS</b><br><b>YEARS</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>DIABETES TYPE II</b><br><b>SEVERE ARTHRITIS</b>   |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br> MD   |  |  |  |
|   | 29c. License number<br><b>D 0069962</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02/22/2011</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FATIMA A NAQVI, MD 6334 CEDAR LANE, LORIAN COLUMBIA, 21044</b>  |  |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

2011 05535

1. For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Ellen L. Matanle

2. Date of Death

Month Day Year  
February 16, 2011

3. Time of Death

2012 hrs

4a. Facility Name (if not institution, give street and number)

5854 Bellanca Drive

4b. City, Town, or Location of Death

Elkridge

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

217-62-8801

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

July 26, 1950

9. Birthplace (State or Foreign Country)

Panama

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5854 Bellanca Dr

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

caretaker

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

Thomas David FitzGerald

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Louise Foote

19a. Informant's Name/Relationship (Type, Print)

Margret Bounds - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1165 N. Blackmoor Dr; Murrells Inlet, SC 29576

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other Specify: in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crem.

Date

2/27/11

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board

Maryland Cremation Services P.O. Box 1413

655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☒ AMENDED #20a-c, 22perFH, G913, 3/1/2011, WS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D. M. Vincenti

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Ronald S. Wade

State  
Registrar

Baltimore, MD 21215-0036

Physician  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05536

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Eugene Miller, Sr</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>11:34 A</b> M   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>212-36-3186</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Nov. 19, 1937</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>4807 Bowland Avenue</b>   |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Grocery Manager</b>   |  | 16b. Kind of Business Industry<br><b>Supermarket</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>David Welby Miller, Sr</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Rutter Borchert</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Steven Miller-son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 Waddy Court-Perry Hall, Maryland 21128</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 20d. Date<br><b>Feb. 19, 2011</b>  |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Andrew L. McFadden</i>   |  | 22. Name and Address of Facility<br><b>Evans Funeral Chapel and Cremation Services<br/>8800 Harford Road-Parkville, Maryland 21234</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic Ischemic Multi-Organ</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | Approximate Interval Between Onset and Death<br><b>Months</b>   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b> |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Andrew L. McFadden</i>   |  | 29c. License number<br><b>DS8303</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 14 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANON J CHARLES MD 6101 N. CHARLES ST TOWSON MD</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  | 32. Registrar's Signature<br><i>Anna A. Parks</i>   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

per mt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05537

1- For  
State  
Registrar

|   |  |  |   |                                   |  |   |   |  |
|---|--|--|---|-----------------------------------|--|---|---|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Santo Louis Montone</b>   |  |   |                                   | 2. Date of Death<br>Month <b>02</b> Day <b>14</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>5:23AM</b>                                       |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Coastal Hospice at the Lake</b>   |  |   |                                   | 4b. City, Town, or Location of Death<br><b>Salisbury</b>   |   | 4c. County of Death<br><b>Wicomico</b>                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-68-6673</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F   |                                   | 7. Age (in yrs. last birthday)<br><b>52</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 15, 1958</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |                                   |  |   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |                                   |  |   |   |  |
|   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Wicomico</b>  |                                   | 10c. City, Town or Location<br><b>Salisbury</b>  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |  |
|   | 10e. Street and Number<br><b>809 E. Williams St.</b>   |  |   |                                   | 10f. Zip Code<br><b>21804</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><b>unk</b><br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  |   |                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>office clerk</b>   |   | 16b. Kind of Business Industry <b>unk</b>                               |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Santo Louis Montone Sr.</b>  |  |   |                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jean Peters</b>  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Christine Roulston - sister</b>   |  |   |                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1875 Campus Dr; Fairborn, Ohio 45324</b>   |   |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |                                   | Date   |   | 20c. Location - City or Town, State                                     |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |                                   | 22. Name and Address of Facility<br><b>State Anatomy Board<br/>655 W. Baltimore St; Baltimore, MD 21201</b>  |   |   |  |
|   | Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>LIVER CIRRHOSIS</b>                 |   |                                   |  |   |   | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |   |                                   |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |  |   |                                   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |   |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |   |                                   |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |                                   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                                   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |                                   |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28d. Describe how injury occurred |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |                                   |  |   |   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                   |  |   |   |  |
|   | 29b. Signature and title of certifier  |  |   |                                   | 29c. License number<br><b>D0058410</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>02/14/2011</b>                |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>G. HARRIS WARE, P.O. Box 1733 Salisbury MD 21802</b>  |  |   |                                   |  |   |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  |   |                                   | 32. Registrar's Signature<br><b>Barbara B. Sparks</b>  |   |   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.Santo Montone Jr  
Baltimore, Maryland 21215-0036permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05538

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Josephine R. Miles

2. Date of Death Month February Day 20 Year 2011

3. Time of Death 12:40 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Keswick Multicare Center

4b. City, Town, or Location of Death Baltimore

4c. County of Death N/A

5. Social Security Number 215-18-5335

6. Sex ☐ M ☒ F

7. Age (In yrs. last birthday) 87 Yrs.

8. Date of Birth (Month, Day, Year) Sept 7, 1923

9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State Maryland

10b. County N/A

10c. City, Town or Location Baltimore

10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 4299 Falls Road

10f. Zip Code Baltimore

10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker

16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last) Ernest Dennstaedt

18. Mother's Name (First, Middle, Maiden Surname) Rachel A. Robbins

19a. Informant's Name/Relationship (Type, Print) Scott Miles Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3920 Beech Avenue, Baltimore, Maryland 21211

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory

20c. Date 2/22/2011

20d. Location - City or Town, State Glen Burnie, Maryland

21. Signature of Funeral Service Licensee Lynn B. Henss

22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. Lung mass - likely cancer, not proven

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death 6 weeks

23b. Immediate Cause (Final disease or condition resulting in death)

23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (specify)

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive cardiovascular disease

23e. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No

26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Dr. Isabelle MacGregor MD

29c. License number D13657

29d. Date signed (Month, Day, Year) February 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR ISABELLE MACGREGOR, 700 W-40th Street, Baltimore, MD 21211

31. Date filed (Month, Day, Year) FEB 24 2011

32. Registrar's Signature

33. State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05539

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bruce McBride

2. Date of Death

Month

Day

Year

3. Time of Death

02

17

2011

7:45 AM

4a. Facility Name (if not institution, give street and number)

Coastal Hospice At the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

212-66-0590

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

53

8. Date of Birth (Month, Day, Year)

08/21/1957

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD10b. County  
Worcester10c. City, Town or Location  
Pocomoke City10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

912 Ocean Highway

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Concrete Finisher

16b. Kind of Business Industry

Construction

17. Father's Name (First, Middle, Last)

Oscar Cropper

18. Mother's Name (First, Middle, Maiden Surname)

Lottie McBride

19a. Informant's Name/Relationship (Type, Print)

Eileen Tatman / Girlfriend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 Ocean Highway, Pocomoke City, MD 21851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Final journey crem.

Date

2/24/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Dorota Marshall

22. Name and Address of Facility

Maryland Cremation Services  
PO Box 1413, Baltimore, MD 21203

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CARCINOMA  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

00058410

29d. Date signed (Month, Day, Year)

02-17-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GTHIAN WANG PO Box 1733 SALISBURY MD 21802

31. Date filed with the Registrar

FEB 24 2011

32. Registrar's Signature

Denise S. Parker

Bruce McBride

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical ExaminerState  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05540

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gordon John Moore, Sr.

2. Date of Death

February 22, 2011

3. Time of Death

3:55 PM

4a. Facility Name (If not institution, give street and number)

Tate House

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

220-36-0930

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/27/1942

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7355 Furnace Branch Road

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

Navy

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Crain Operator

16b. Kind of Business/Industry

General Electric

17. Father's Name (First, Middle, Last)

Alison Gordon Moore

18. Mother's Name (First, Middle, Maiden Surname)

Genevieve Mary Dalfonzo

19a. Informant's Name/Relationship (Type, Print)

Sandra J. Dubois / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7702 Harvest Hills Ct., Mt. Airy, MD 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Final Journey crem.

Date

2/25/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Dorota Marshall

22. Name and Address of Facility

Maryland Cremation Services  
PO Box 1413, Baltimore, MD 21203

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiovascular Disease

Approximate Interval Between Onset and Death

Sequentially list conditions,

if any, leading to the final

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

- a. Due to (or as a consequence of):
- b. Due to (or as a consequence of):
- c. Due to (or as a consequence of):
- d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Sandra J. Dubois

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No.

2011 05541

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Morning

2. Date of Death

February 20, 2011

3. Time of Death

7:36 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

216-38-7257

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

68 Yrs.

8. Date of Birth

8-19-1942

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

md

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4725 Three Oaks Road

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business Industry

Domestic

17. Father's Name (First, Middle, Last)

Clarence McAllister

18. Mother's Name (First, Middle, Maiden Surname)

Annie Bowie

19a. Informant's Name/Relationship (Type, Print)

Milton Morning/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4725 Three Oaks Road, Baltimore, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium, or other place)

Morning Family

Date

2-27-2011

20c. Location - City or Town, State

Tarboro NC

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

Vaughn C. Greene Funeral Services

8728 Liberty Road, Randallstown, MD 21133

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

Approximate Interval Between Onset and Death

1 day

23b. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Sepsis

a. Due to (or as a consequence of):

perforated viscous

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cardiomyopathy

Acute renal Failure

Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael S. Ballo M.D.

29c. License number

056226

29d. Date signed (Month, Day, Year)

February 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael S. Ballo 5401 Old Court Rd Randallstown Maryland 21133

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Anna J. Parker

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05542

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Wayne Meredith

2. Date of Death  
Month Day Year  
February 11, 20113. Time of Death  
0105 hrs

4a. Facility Name (if not institution, give street and number)

837 McKim Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

219-96-2322

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

4-18-1965

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

837 McKim Street

10f. Zip Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

na

17. Father's Name (First, Middle, Last)

Samuel Meredith

18. Mother's Name (First, Middle, Maiden Surname)

Jacqueline Westmoreland

19a. Informant's Name/Relationship (Type, Print)

Samuel Meredith-Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2717 W. North Avenue Balto, MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Carmel Cem

Date

2-19-2011

20c. Location - City or Town, State

Balto, MD

21. Signature of Funeral Service Licensee

*Charles M. Hall*

22. Name and Address of Facility

March East F/H

1101 E. North Avenue Balto, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ruptured Berry Aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

23a,b,27 per me g913 3-1-11 vt

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Carol Allan*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 11, 2011

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

*James A. Jones*

State Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05543

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel A McGeehan

2. Date of Death

Month Day Year  
Feb 22 2011

3. Time of Death

10:40P M

4a. Facility Name (If not institution, give street and number)

Copper Ridge

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

199-22-4442

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

8-12-1928

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1606 Exeter Rd.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cleaner

16b. Kind of Business Industry

Service

17. Father's Name (First, Middle, Last)

John H. Adler Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Irene Welch

19a. Informant's Name/Relationship (Type, Print)

Bonnie Cullom-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1606 Exeter Rd., Westminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

South Carroll

Date

2-23-11

20c. Location - City or Town, State

Winfield, MD

21. Signature of Funeral Service Licensee

Phonias D. Little III

22. Name and Address of Facility

Fletcher Funeral Home

254 E. Main St., Westminster, MD 21157

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. H. Y. MD

29c. License number

D0058137

29d. Date signed (Month, Day, Year)

2/23/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilbur Kuo 295 Stoner Ave St 307 Westminster MD 21157

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

D. J. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05544

1- For  
State  
Registrar

|   |   |  |   |  |  |  |
|---|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lillian F. Mankoff</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>21</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>6:10</b> PM   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Harmony Hall Care Facility</b>   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |  | 4c. County of Death<br><b>Howard</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>129-03-1742</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                   | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>07/30/1917</b>   | 9. Birthplace (State or Foreign Country)<br><b>New York, NY</b>  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Howard</b>   | 10c. City, Town or Location<br><b>Columbia</b>  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>9505 Dawnblush Court</b>   |  |   | 10f. Zip Code<br><b>21045</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Social Worker</b>                     |  | 16b. Kind of Business Industry<br><b>Social Services</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Herman Flacks</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Goldstein</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward A. Mankoff (Son)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9505 Dawnblush Court, Columbia, MD 21045</b> |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Conejo Mountain Cem.</b>   |  | 20c. Location - City or Town, State  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Avenue, Baltimore, Maryland 21229</b>                              |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Senile Dementia</b><br>Due to (or as a consequence of):<br>b. <b>Hypertension</b><br>Due to (or as a consequence of):<br>c. <b>Chronic Kidney Disease</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b><br><b>years</b> |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>  |   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Katherine Janta CRNP</b>  |   | 29c. License number<br><b>R121680</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>FEB 22 2011</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Katherine Janta 6334 Cedar Lane Columbia MD 21044</b>  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |   | 32. Registrar's Signature<br> |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05545

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Barbara McCall

2. Date of Death

Month Day Year

February 21 2011

3. Time of Death

9:50 AM

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

214-54-6446

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 5, 1950

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

503 McElderry St. Apt. 104

10f. Zip-Code

21202

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Clyde Timmons

18. Mother's Name (First, Middle, Maiden Surname)

Audrey James

19a. Informant's Name/Relationship (Type, Print)

Cheyenne Webb/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

718 W. Fayette St. Baltimore, Md 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

March 1, 2011

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO. MD 21213

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

February 21 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel R. Khanderker

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05546

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

REGINALD NEWSOME

2. Date of Death

Month Day Year  
2-21-2011

3. Time of Death

11:47 AM

4a. Facility Name (if not institution, give street and number)

8 Straw Hat Road Apt. 2C

4b. City, Town, or Location of Death

Owings Mills

4c. County of Death

Baltimore

5. Social Security Number

218-46-8834

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11, 01, 1946

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8 Straw Hat Road Apt. 2C

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Grant Specialist

16b. Kind of Business Industry

AOA-DHHS

17. Father's Name (First, Middle, Last)

John Wilmer Newsome

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Hansley

19a. Informant's Name/Relationship (Type, Print)

Diane Newsome/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Straw Hat Road Apt. 2C Owings Mills MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

1st Memorial Park

Date

3-5-2011

20c. Location City or Town, State

San Antonio, TX

21. Signature of Funeral Service Licensee

Vaughn C. Greene

22. Name and Address of Facility

Vaughn C. Greene Funeral Services  
8728 Liberty Road, Randallstown, MD 21133

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Bronchiolitis obliterans Organising

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Transplantation  
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daleah Salameh

29c. License number

D20292

29d. Date signed (Month, Day, Year)

Feb 23, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 CROSSROADS DR STE 101, OWINGS MILLS, MD 21117

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Brenda A. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05547

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William H. Neblett

2. Date of Death

Month 2 Day 23 Year 2011

3. Time of Death

4:05 AM

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Balto.

Funeral  
Director

5. Social Security Number

220-14-4158

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

2-17-1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4319 Robertson Ave

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Longshoreman

16b. Kind of Business Industry

Steamship Trade

17. Father's Name (First, Middle, Last)

Guss Neblett Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anita Gamby

19a. Informant's Name/Relationship (Type, Print)

Joyce Hines fiancee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4319 Robertson Ave Balto Md - 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Vet Cem

Date

3-2-2011

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licenses

Carlton E. Douders

22. Name and Address of Facility

Carlton E. Douders Funeral Service P.A.  
1701 McMillan St. Balto. Md - 2121723a. Part 1. Enter the disease, or complications that cause death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each lineImmediate Cause (Final  
disease or condition  
resulting in death)

a. Dementia, Alzheimer type

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Douders

29c. License number

D58303

29d. Date signed (Month, Day, Year)

February 23 2011

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Anon J CHARLES MD 601 N. Charles ST Towson MD

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Douders

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

AMEND ITEM#19a, b, per FH, C912.2/24/2011, WS  
State of Maryland / Department of Health and Mental Hygiene  
amend #5 Per INF C913.3/04/2011 JH

Reg. No.

2011 05548

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>James Howard Owens</b>  |  | 2. Date of Death<br>Month <b>02</b> Day <b>21</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>10:49A</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>218-14-5147</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>11/07/1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |  |  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 10e. Street and Number<br><b>10101 Governor Warfield Pkwy #116</b>   |  | 10f. Zip Code<br><b>21044</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.                                |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Real Estate Manager</b>  |  | 16b. Kind of Business Industry<br><b>Bell Atlantic</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Owens</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Alice Bryan</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Loretta Owens Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>James Carl Owens Son 6903 McEl 10101 Governor Warfield Pkwy Columbia, MD</b> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus</b>   |  | 20c. Location - City or Town, State<br><b>2/28/2011 Baltimore, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>PAAS 200553</b>  |  | 22. Name and Address of Facility<br><b>Vaughn C. Greene F.S. 1905 York Road Baltimore, Md. 21212</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive Heart failure</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b>  |  |  |  |  |  |
| Approximate Interval Between Onset and Death   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Ilness</b>   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Inpatient Hospice</b>   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Kemp</b>   |  | 29c. License number<br><b>R125808</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/21/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anne Lewis Villanueva, Sr</b><br><b>6701 N. Charles St., Ste 4105, Baltimore, MD 21204</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  | 32. Registrar's Signature<br><b>Ann S. Jones</b>   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05549

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
|---|---|---------------------------------|---|---|---|--|---|--|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Doris Emma Preston</b>                             |                                 |   |   | 2. Date of Death<br>Month <b>2</b> Day <b>24</b> Year <b>2011</b> |  |   |  | 3. Time of Death<br><b>7:10 A M</b>                                     |                                   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN Square Hospital</b> |                                 |   |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>           |  |   |  | 4c. County of Death<br><b>Baltimore</b>                                 |                                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-01-7085</b>   |                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.                  |  | 8. Date of Birth (Month, Day, Year)<br><b>August 02, 1919</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Maryland</b>  |                                   |  |  |
|   | Usual Residence of Decedent   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Rosedale</b>  |   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |                                   |  |  |
| 10e. Street and Number<br><b>4724 Bucks Schoolhouse Road</b>  |   |                                 |   | 10f. Zip Code<br><b>21237</b>   |   |  |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |                                   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>N/A</b>  |   |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |  |   | 16b. Kind of Business/Industry<br><b>At Home</b>   |   |                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Albert Evans</b>  |   |                                 |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Jane Estelle Stevens</b>  |   |  |   |                                   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Preston, Jr. (Son)</b>  |   |                                 |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1240 Westchester Greensboro, Georgia 30642</b>   |   |  |   |                                   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>  |   | Date<br><b>February 27, 2011</b>   |   | 20c. Location - City or Town, State<br><b>Rosedale, Maryland</b>                                   |   |                                   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |                                 |   |   |   | 22. Name and Address of Facility<br><b>Evans Funeral Chapel &amp; Cremation Services Parkville<br/>8800 Harford Road Parkville, Maryland 21234</b>   |   |  |   |                                   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (final disease or condition resulting in death)<br>a. <b>urinary tract infection</b><br>Due to (or as a consequence of):<br>b. <b>sepsis</b><br>Due to (or as a consequence of):<br>c. <b>metastatic breast cancer</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year              |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                 |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |   |                                   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |                                 |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   | 28d. Describe how injury occurred |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |                                   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   |                                 |   |   |   | 29c. License number<br><b>D69198</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY, 24, 2011</b>                                   |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR John Kottarathil 4000 FRANKLIN Square DR BALTO md 21237</b>   |   |                                 |   |   |   |  |   |  |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |   |                                 |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |  |   |                                   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05550

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Louise Pyle</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>21</b> Year <b>2011</b>  |  |  |  | 3. Time of Death<br><b>1:44 P M</b>  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  |  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-10-3473</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 18, 1916</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>2211 W. Rogers Avenue; Apt A-17</b>   |  |   |  | 10f. Zip Code<br><b>21209</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                    |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>secretary</b>  |  |  | 16b. Kind of Business Industry<br><b>unk</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Howard Renoux Reese</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Erma Virginial Royston</b>  |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Clark - granddaughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1359 Oakledge Ct; Pittsburgh, PA 15241</b>  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |  | 20c. Location - City or Town, State  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board<br/>655 W. Baltimore St; Baltimore, MD 21201</b>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>years</b>  |  |   |  |   |  |  |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown                           |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pneumonia</b> |  |  |   |  |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>                                |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |  |  |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |  |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>R139326</b>                          |  | 29d. Date signed (Month, Day, Year)<br><b>February 21 2011</b>                                     |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kathryn Bosch CRNP 6701 W. Chapel Street Towson MD 21204</b>  |  |   |  |   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Virgil Henry Purdham</b>   |   |  |  | 2. Date of Death<br>Month <b>02</b> Day <b>18</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>6:15 PM</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>921 John Avenue</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-26-5798</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | 8. Date of Birth<br>Month <b>06</b> Day <b>12</b> Year <b>1930</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>921 John Avenue</b>  |   |  |  | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                          |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  | 16b. Kind of Business Industry<br><b>Trucking Industry</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Virgil H. Purdham, Sr.</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Onada Rowe</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce J. Purdham (Spouse)</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>921 John Avenue, Baltimore, Maryland 21229</b>   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |  | Date<br><b>02/24/2011</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Hubbard Funeral Home, Inc.<br/>4107 Wilkens Avenue, Baltimore, Maryland 21229</b>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>EMPHYSEMA</b><br>Due to (or as a consequence of):<br>b. <b>Chronic bronchitis</b><br>Due to (or as a consequence of):<br>c. <b>Pulmonary hypertension</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b><br><b>Lymphoma</b>  |   |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M                         |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28d. Describe how injury occurred                |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D 21649</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>February 21, 2011</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SANBANDY BASKARAN 3455 Wilkens Ave. BALTIMORE MD 21229</b>  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

641



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05552

1- For State  
RegistrarPhysician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Prince

2. Date of Death  
Month Day Year  
February 22, 20113. Time of Death  
0940 hrsFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

214-86-1449

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

January 4, 1975

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Baltimore10c. City, Town or Location  
Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2916 Dunmurry Road Apt A

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Kenneth Smith

18. Mother's Name (First, Middle, Maiden Surname)

Deborah Cook

19a. Informant's Name/Relationship (Type, Print)

Ted Prince Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2916 Dunmurry Road Apt A., Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.  
7110 Sollers Point Road, Dundalk, MD. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Saddle Pulmonary Thromboembolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Deep Venous Thrombosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accidental 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

(Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pamela E. Southall, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 23, 2011

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Diana A. Spack

State Registrar

ORIGINAL

OCME

Baltimore, MD 21215-0036

Physician  
Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05553

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy L. Rolka

2. Date of Death

2/17/2011

3. Time of Death

2:30pm M

4a. Facility Name (if not institution, give street and number)

1302 Haubert Street

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-18-7944

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5/24/1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1302 Haubert Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Herbert Pierson

18. Mother's Name (First, Middle, Maiden Surname)

Myra Gardner

19a. Informant's Name/Relationship (Type, Print)

Dorothea D. Scott / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1302 Haubert Street, Baltimore MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

2/21/11

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Victor P. Doda

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.

1501 East Fort Ave Baltimore MD 21230

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. heart disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

b. hypertension

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. O'Mahony, MD

29c. License number

D46389

29d. Date signed (Month, Day, Year)

Feb. 19, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. O'Mahony, MD 301 St Paul Baltimore, MD 21202

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05554

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Gladys Rupp

2. Date of Death

February 18, 2011

3. Time of Death

6:32 PM

4a. Facility Name (if not institution, give street and number)

102 W. Aztec Street

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

214-30-4862

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 7, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

102 W. Aztec Street

10f. Zip Code

21001

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Franklin Martin

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Edna Dovenbarger

19a. Informant's Name/Relationship (Type, Print)

Melissa Placide / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13804 Long Cove Ct. Midlothian, Virginia 23112

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Evans Funeral Chapel  
Bel Air

Date

Feb. 23,  
2011

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

Jeffrey R. Testerman

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Service-Bel Air  
3 Newport Drive Forest Hill, Maryland 2105023a. Print, enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Lung Cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D0063981

29d. Date signed (Month, Day, Year)

02/22/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Lee, M.D. 669 Revolution St. Havre de Grace, MD 21078

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Diana A. Sparks

State  
RegistrarPhysician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2011 05555

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Vincent Ryan

2. Date of Death

February 18 2011

3. Time of Death

9:45 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

109 Glen Argyle Rd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

071-20-2245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 21, 1928

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

109 Glen Argyle Rd.

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1946-48

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

teacher

16b. Kind of Business Industry

education

17. Father's Name (First, Middle, Last)

Stephen Vincent Ryan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Catherine Cramer

19a. Informant's Name/Relationship (Type, Print)

Camilla Ryan/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Glen Argyle Rd. Baltimore, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans

Date

Feb. 24, 2011

20c. Location - City or Town, State

Owings Mills, Maryland

21. Signature of Funeral Service Licensee

John D. Mitchell

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Rd. Baltimore, MD 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): OSTEOMYELITIS

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of): DIABETES

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 ☐

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark Saba

29c. License number

00058656

29d. Date signed (Month, Day, Year)

FEBRUARY 22 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Saba, MD 7505 Osler Dr. Towson, MD 21204

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

John D. Mitchell

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 055556

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

VELVA S RUNGE

2. Date of Death

Month Day Year  
2 15 2011

3. Time of Death

2130A M

4a. Facility Name (if not institution, give street and number)

FREDERICK VILLA

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

236-44-8931

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/08/1929

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1055 Rockhill Avenue

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Second (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cafeteria Manager

16b. Kind of Business Industry

Food

17. Father's Name (First, Middle, Last)

James Sims

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Malcolm

19a. Informant's Name/Relationship (Type, Print)

Walter Runge / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1055 Rockhill Ave., Baltimore, MD 21229

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Final Journey crem.

Date

2/20/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Donota Marshall

22. Name and Address of Facility

Maryland Cremation Services  
PO Box 1413, Baltimore, MD 2120323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ATHEROSCLEROTIC CEREBROVASCULAR DISEASE

Approximate  
Interval Between  
Onset and Death

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VASCULAR DEMENTIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Tasneem Lachari MD

29c. License number

D 28535

29d. Date signed (Month, Day, Year)

2/15/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM LACHARI, MD 2835 SMITH AVE, BALTO MD 21209

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Robert B. Parker

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05557

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley

Ann

Rafinello

2. Date of Death

February 21, 2011

3. Time of Death

7:30 a.m.

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-40-8566

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 24, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

937 Bardswell Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business Industry

Bank

17. Father's Name (First, Middle, Last)

James Clifton Long, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ethelyn Offer

19a. Informant's Name/Relationship (Type, Print)

John Rafinello (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

937 Bardswell Rd., Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/26/11

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Loudon Park Funeral Home

3620 Wilkens Ave., Baltimore, MD 21229

23a. List the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Leukemia of uterus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D0071187

29d. Date signed (Month, Day, Year)

2/21/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Shaheen, 6701 N. Charles St. Suite 4105, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Susan A. Spaw

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05558

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Nicholas Ray Jr.

2. Date of Death

February 22 2011

3. Time of Death

5:10A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Glen Burnie Health &amp; Rehabilitation

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

214-12-1076

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 27, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1105 Armistead St.

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business Industry

BGE

17. Father's Name (First, Middle, Last)

George N. Ray, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Olive V. Johnson

19a. Informant's Name/Relationship (Type, Print)

James Ray/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6500 Kimono Ct. Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crematory

Feb Date 28

2011

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

L. J. Hackett MO1594

22. Name and Address of Facility

Singleton Funeral &amp; Cremation Services PA 1 2nd Ave Sw Glen Burnie, MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter U.S. Injury Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aneurysm

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Kunmi Wojcikowski

29c. License number

D63726

29d. Date signed (Month, Day, Year)

2, 22, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1406 crain highway Glen Burnie Maryland 21061

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

L. J. Hackett

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05559

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Madeline Svec

2. Date of Death  
Month Day Year

February 22, 2011

3. Time of Death

4:35 PM

Funeral  
Director

4a. Facility Name, (If not institution, give street and number)

St. Elizabeth Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

215-01-8787

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

10-14-1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

909 NORTH PORT STREET

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

PAYROLL CLERK

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

JOSEPH SVEC

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES ( SKRIVAN )

19a. Informant's Name/Relationship (Type, Print)

MARK SUPIK/NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2225 EAST PRATT STREET BALTIMORE, MD 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HOLY REDEEMER CEM 3-2-2011 BALTIMORE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME  
1211 CHESACO AVE ROSEDALE, MD 2123723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral vascular accident

Due to (or as a consequence of):

b. Dysphagia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia  
Hypertension  
Hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D55391

29d. Date signed (Month, Day, Year)

February 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ming Yi 3326 Benson Avenue, Baltimore, Maryland 21227

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05560

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen S. Showers

2. Date of Death

February 21, 2011

3. Time of Death

10:20 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

1205 Trappe Lane

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

169-36-2148

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

8. Date of Birth

Apr 6, 1943

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1205 Trappe Lane

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administration

16b. Kind of Business Industry

University

17. Father's Name (First, Middle, Last)

Leon P. Showers

18. Mother's Name (First, Middle, Maiden Surname)

Lucille V. Strickland

19a. Informant's Name/Relationship (Type, Print)

Mariann Showers / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1205 Trappe Lane; Towson, MD 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lind Memorial Cemetery

Date

2/25/2011

20c. Location - City or Town, State

Lewistown, PA

21. Signature of Funeral Service Licensed

22. Name and Address of Facility

1050 York Road  
Ruck Towson Funeral Home, Inc. Towson, MD 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PANCREATIC CANCER

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

1 year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Breslyn A Wilk, MD

29c. License number

MD-69614

29d. Date signed (Month, Day, Year)

FEBRUARY 22 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRESLYN A WILK, MD 401 NORTH BROADWAY ROOM 1363  
BALTIMORE, MARYLAND 21231

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05561

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Ann Snider

2. Date of Death

Month Day Year  
FEBRUARY 20, 2011

3. Time of Death

8:15P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

422-32-5026

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 29, 1927

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

639 Regester Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 year

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Lawrence Bernard Hale

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth McMichael

19a. Informant's Name/Relationship (Type, Print)

James F. Snider, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

639 Regester Avenue Baltimore, Maryland 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem. Grdns.

Date

2-24-11

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

St. Joseph Ferrasse

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Road Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident Investigation3 ☐ Suicide 6 ☐ Could not be4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check

only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

St. Joseph Ferrasse

29c. License number

D30263

29d. Date signed (Month, Day, Year)

2-20-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

St. Joseph Ferrasse

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

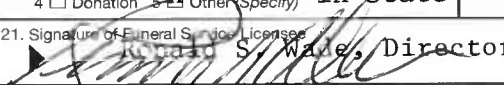
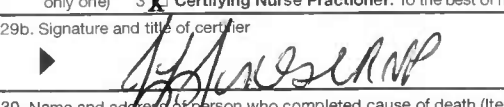

Certificate of Death

Reg. No. 2011 05562

1- For State Registrar

Physician/  
Medical  
Examiner

Funeral  
Director

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Stiwinter</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>20</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>12:45 A M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Stella Maris Hospice</b>   |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>217-24-7602</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov 12, 1928</b>   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |  |
| Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   | 10b. County  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>102 E. Elm Avenue</b>  |  | 10f. Zip Code<br><b>21206</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>diesel mechanic</b>   |  | 16b. Kind of Business Industry<br><b>automotive</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last) <b>unk</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Etta Melinda Hedden</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wilma Stiwinter - wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 E. Elm Avenue; Baltimore, Maryland 21206</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |  | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Director Licensee<br>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board</b><br><b>655 W. Baltimore St; Baltimore, MD 21201</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  | Approximate Interval Between Onset and Death |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>  |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.              |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>R149792</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/21/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

FEBRUARY 20, 2011 12:45 a.m.  
Baltimore, Maryland 21215-0036

CHARLES STIWINTER  
Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05563

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

RAMCHAND RAVI SANHAI

2. Date of Death

Month Day Year  
Feb 23 2011

3. Time of Death

00:24am

4a. Facility Name (if not institution, give street and number)

Season's Hospice

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

591-72-3965

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

04/12/1955

9. Birthplace (State or Foreign Country)

Trinidad

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Owings Mills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4608 Waterfall Court

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Psychologist

16b. Kind of Business Industry

Healthcare

17. Father's Name (First, Middle, Last)

Sanhai

18. Mother's Name (First, Middle, Maiden Surname)

Ajodha

19a. Informant's Name/Relationship (Type, Print)

Wendy Sanhai / Ex-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9808 Sherwood Farm Road, Owings Mills, MD

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Final Journey crem.

Date

2/24/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Dorota Marshall

22. Name and Address of Facility

Maryland Cremation Services  
PO Box 1413, Baltimore, MD 21203

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiothrombotic Event

Due to (or as a consequence of):

Arteriosclerotic Cardiovascular Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Inpatient hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. S. Rajapakse, MD

29c. License number

D0057465

29d. Date signed (Month, Day, Year)

2/22/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapakse, MD 2835 Smith Ave S-203 Baltimore MD 21209.

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Sandra A. Spaul

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

5v

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05564

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Mae Stanley

2. Date of Death

FEB 20 2011

3. Time of Death

3:00A M

4a. Facility Name (If not institution, give street and number)

Augsburg Lutheran Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

217-16-3056

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

01 02 22

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2121 Windsor Garden Lane Apt 108A

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

na

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

House

17. Father's Name (First, Middle, Last)

William Summerville

18. Mother's Name (First, Middle, Maiden Surname)

Emma Henson

19a. Informant's Name/Relationship (Type, Print)

Marlene Parker-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2307 Kelox Road, Baltimore, Md 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion

Date

2/28/2011

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Sandra C. Shupak

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ATHEROSCLEROTIC CEREBROVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sasneem Lalhani MD

29c. License number

D 28595

29d. Date signed (Month, Day, Year)

2/21/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM LAKHANI, MD 2835 SMITH AVE BALTO MD 21209

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Sandra C. Shupak

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

05565

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anna Catherine Seiders

2. Date of Death

Month Day Year  
February 19, 2011

3. Time of Death

2:40 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

213-01-9824

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

8. Date of Birth (Month, Day, Year)

Oct 13, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Walther Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Aloysius Goedeke

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Trageser

19a. Informant's Name/Relationship (Type, Print)

Roy Seiders / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3508 Linbelle Terrace Parkville, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

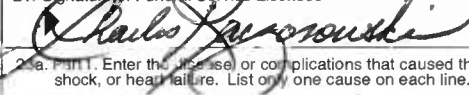
Date

February 23, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Kaczorowski Funeral Home, P.A.  
1201 Dundalk Avenue Baltimore, Md. 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure  
Due to (or as a consequence of):b. Pneumonia  
Due to (or as a consequence of):c. Congestive heart failure  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier  
Yuling Zhang, M.D.

29c. License number

D70605

29d. Date signed (Month, Day, Year)

Feb, 19, 2011

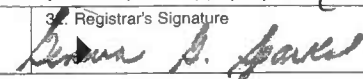
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yuling Zhang, M.D. 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #23b Per: PHY G912 2/24/2011  
State of Maryland Department of Health and Mental Hygiene1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2011 05566

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LORETTA SCHNESSEL</b>  |   | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 14 2011</b>   |  | 3. Time of Death<br><b>09:30 AM</b>   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>JOHN HARKINS BAYVIEW MEDICAL CENTER</b>  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death   |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-14-7615</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 4, 1924</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|  | Usual Residence of Decedent   |   |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Md.</b>  | 10b. County   | 10c. City, Town or Location<br><b>Baltimore City</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>812 Umbra Street</b>   |   | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)                        |  |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>  |   | 16b. Kind of Business Industry<br><b>Own Home</b>   |  |   |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Albert Lasek</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Barczak</b>  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Herman Schnessel/Husband</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>812 Umbra Street Baltimore, Maryland 21224</b>    |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>February St. Stanislaus Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue Baltimore, Md. 21222</b>                                    |  |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>INTRACEREBRAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br>b. <b>Stroke</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>12 HOURS</b> |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |   |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>RES-000</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 14, 2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jose Luis Lopez, M.D. 4940 Eastern Avenue Baltimore, MD 21224</b>   |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |   | 32. Registrar's Signature<br>   |   |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05567

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Lillian Summers</i>   |  |   |  | 2. Date of Death<br>Month <i>Feb.</i> Day <i>23</i> Year <i>2011</i>   |  |  |  | 3. Time of Death<br><i>7:30 PM</i>   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><i>Gilchrist Center</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>Towson</i>  |  |  |  | 4c. County of Death<br><i>Baltimore</i>  |  |  |  |
| 5. Social Security Number<br><i>218-26-2658</i>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>80</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>Dec 21, 1930</i> |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |  |  |  |
| 10a. State<br><i>md.</i>   |  |   |  | 10b. County<br><i>N/A</i>  |  | 10c. City, Town or Location<br><i>Baltimore</i>            |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><i>5318 Norwood Ave</i>  |  |   |  | 10f. Zip Code<br><i>21207</i>  |  |  |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>N/A</i>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>House Keeper</i>   |  |  |  | 16b. Kind of Business Industry<br><i>St. Mary's Seminary</i>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Gonzley Summers</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Inez Price</i>   |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Gloria Jenkins - daughter</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1826 N. Bond St. Balto. md. 21218</i>  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>MT. Zion Cem</i>  |  | Date<br><i>2-24-2011</i>                                   |  | 20c. Location - City or Town, State<br><i>Lansdowne, md.</i>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Nancy M. Wallace</i>   |  |   |  | 22. Name and Address of Facility<br><i>3405 W. Franklin St<br/>Nancy M. Wallace F.S. Balto. md. 21239</i>  |  |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Lung Cancer</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                    |  |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>months</i>                                      |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Worship</i> |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M                                   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Dr. Charles</i>  |  |   |  | 29c. License number<br><i>D58303</i>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><i>February 23 2011</i>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>ARON J CHARLES MD 6701 N Charles St Towson MD</i>   |  |   |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 24 2011</i>  |  |   |  | 32. Registrar's Signature<br><i>Benjamin A. Jones</i>  |  |  |  |  |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05568

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clifton Earl Tingstrom

2. Date of Death

February 16, 2011

3. Time of Death

7:45 am

4a. Facility Name (if not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-26-8595

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

8. Date of Birth

10/28/1930

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

929 Dunellen Drive

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laboratory Owner

16b. Kind of Business Industry

medical

17. Father's Name (First, Middle, Last)

Clifton Earl Tingstrom Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mae Fenstermacher

19a. Informant's Name/Relationship (Type, Print)

Catherine M. Tingstrom /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

929 Duellen Drive, Baltimore, MD 21286

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Final Journey Crem.

Date

2/20/2011

20c. Location - City or Town, State

Woodbine, MD

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

Maryland Cremation Services  
PO Box 1413, Baltimore, MD 2120323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. **CEREBROVASCULAR ACCIDENT**

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) **HOSPICE**

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

J. Jones

29c. License number

R149792

29d. Date signed (Month, Day, Year)

2/16/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

J. Jones

FEBRUARY 16, 2011 7:45 a.m.  
Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transitCLIFTON TINGSTROM  
Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05569

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Eleanor Thomas-Dyson

2. Date of Death

Month FEB Day 20 Year 2011

3. Time of Death

4:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ST AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

580-15-8260

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

8. Date of Birth

Month FEB Day 20 Year 2011

9. Birthplace (State or Foreign Country)

Antigua

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

61 King Richard Court

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

Masters Degree

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do not use retired)

Professor of Surgical Technology

16b. Kind of Business/Industry

Baltimore City Community College

17. Father's Name (First, Middle, Last)

Zephaniah Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Greenidge

19a. Informant's Name/Relationship (Type, Print)

Juliana Thomas (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

61 King Richard Court, Rosedale, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

David Ridge Cemetery

Date

2/26/2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Vaughn C. Greene Funeral Services  
4906 York Rd. Balto MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast CA METASTATIC TO BRAIN

Approximate Interval Between Onset and Death

1-2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

PNEUMONIA

3 days

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

P25490

29d. Date signed (Month, Day, Year)

FEB 20 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ali QAMAR, 900 S CATON AVE, BALTIMORE, MD, 21229

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 05570

Reg. No.

|   |   |  |   |  |   |  |
|---|---|--|---|--|---|--|
| Physician/<br>Medical Examiner                | 1. For State Registrar  |  | 2. Date of Death<br>Month Day Year<br>February 18, 2011   |  | 3. Time of Death<br>1115 hrs  |  |
|   | 1. Decedent's Name (First, Middle, Last)<br><i>George Anthony Turner</i>  |  | 4a. Facility Name (if not institution, give street and number)<br>2828 Brighton Street  |  | 4b. City, Town, or Location of Death<br>Baltimore   |  |
| Funeral Director                              | 5. Social Security Number<br>220-764207   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>50 Yrs.   |  |
|   | 8. Date of Birth (MM/DD/YYYY)<br>4-29-1960  |  | 9. Birthplace (State or Foreign Country)<br>MD  |  | 10. Usual Residence of Decedent   |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD  |  | 10b. County   |  | 10c. City, Town or Location<br>Baltimore  |  |
|   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>2828 Brighton Street  |  | 10f. Zip Code<br>21214  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:   |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Cosmetologist</i>   |  |
| To Be Completed by Physician/Medical Examiner | 16b. Kind of Business/Industry<br><i>Cosmetology</i>  |  | 17. Father's Name (First, Middle, Last)<br><i>George Turner</i>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Emma Williams</i>   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Emma Turner (mother)</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3018 Fendell Rd, Baltimore, MD 21207</i>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Woodlawn</i>   |  | 20c. Location - City or Town, State<br><i>Baltimore MD</i>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Vaughn C. Greene</i>  |  | 22. Name and Address of Facility<br><i>Vaughn C. Greene Funeral Services<br/>8728 Liberty Road, Randallstown, MD 21133</i>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac arrest, shock, or respiratory failure. List only one cause on each line.<br><i>Hypertensive Cardiovascular Disease complicated by</i>                             |  | 23b. Immediate Cause (Final disease or condition resulting in death)<br><i>Chronic methadone use</i>  |  | 23c. Due to (or as a consequence of):   |  |
|   | 23d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>23a, pt. II, 27, g915 5-17-11 sm</i>  |  | 23e. Due to (or as a consequence of):   |  | 23f. Due to (or as a consequence of):   |  |
| To Be Completed by Physician/Medical Examiner | 23g. UNPENDED <input checked="" type="checkbox"/> AMENDED <input type="checkbox"/>  |  | 23h. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |
|   | 23d. Date of delivery<br>Month Day Year   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Human Immunodeficiency Virus</i>  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
|   | 29b. Signature and title of certifier<br><i>Mary G. Ripple MD</i>   |  | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>February 19, 2011  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a)<br>Mary G. Ripple MD, Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223   |  | 31. Date filed (Month, Day, Year)<br>FEB 24 2011  |  |   |  |
|   | 32. Registrar's Signature<br><i>George A. Turner</i>  |  | 33. State Registrar<br>OCME   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05571

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARILYN

TUTTLEMAN

2. Date of Death

Month Day Year  
FEBRUARY 22 2011

3. Time of Death

09:35 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

9906 INGLEMER DRIVE

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

383-48-5269

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/31/1949

9. Birthplace (State or Foreign Country)

MI

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9906 INGLEMER DRIVE

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATOR

16b. Kind of Business Industry

NATIONAL INSTITUTES OF HEALTH

17. Father's Name (First, Middle, Last)

MAX

TUTTLEMAN

18. Mother's Name (First, Middle, Maiden Surname)

RHEA

SINGER

19a. Informant's Name/Relationship (Type, Print)

BARBARA SITRIN / COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 TIMBERLAND DRIVE, WILLIAMSVILLE, NY 14221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MACHPELAH CEMETERY

Date

02/23/2011

20c. Location - City or Town, State

FERNDAL, MI

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
6 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0035045

29d. Date signed (Month, Day, Year)

02/23/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILIP HENJUM, MD 18109 PRINCE PHILIP DRIVE, #200, OLNEY, MD 20832

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

MARILYN TUTTLEMAN  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2011 05572

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stanley Alexander Uzarowski

2. Date of Death

Month 2/18/11 Year

3. Time of Death

3:30am

4a. Facility Name (if not institution, give street and number)

Hospice of the Chesapeake, Tate House

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

220-18-4591

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year) 10/25/25

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19 Greenwood Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

US Navy

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Electrical Tech.

16b. Kind of Business Industry

Westinghouse

17. Father's Name (First, Middle, Last)

Alexander Uzarowski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Pilak

19a. Informant's Name/Relationship (Type, Print)

Dolores R. Uzarowski/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Greenwood Avenue, Glen Burnie MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arden Crematory

Date

2/24/2011

20c. Location - City or Town, State

Hanover MD

21. Signature of Funeral Service Licensee

Victor P. Doda

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.

1501 East Fort Avenue, Baltimore MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

a. Actinomycetosis

Due to (or as a consequence of):

b. T-cell large granular lymphocyte (TCL) 13 months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

2 days

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Diffuse large cell lymphoma

② Small lymphocytic leukemia

③ ASITU

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence6 ☒ Other (Specify)

In my home

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

M

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check

only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

m.p.

29c. License number

044944

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smiley Walker m.p. 211 West 40th Street Baltimore Maryland 21211

31. Date of Death

FEB 24 2011

32. Registrar's Signature

Ann D. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05573

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Joseph Urban

2. Date of Death

Month Day Year  
2 22 2011

3. Time of Death

1:45 PM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-18-7299

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

8. Date of Birth (Month, Day, Year)

March 9, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3105 Northwind Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. 1945-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

William Urban

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Dvorak

19a. Informant's Name/Relationship (Type, Print)

Mr. Charles M. Urban (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 Wilson Point Road Middle River, Maryland 21220

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel  
Bel Air

Date

Feb. 25  
2011

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

Jeffrey R. Testerman

22. Name and Address of Facility

Evans Funeral Chapel & Cremation Services - Parkville  
8800 Harford Road, Parkville Maryland 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

2/22/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Constantine Burgan 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

D. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05574

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Irene J. Underwood</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>11</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>6:55 A</b> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Potomac Valley Nursing Home</b>   |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>577-54-2229</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1912</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>France</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Chevy Chase</b>   |  | 10c. City, Town or Location<br><b>Montgomery</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>8100 Connecticut Ave; #1103</b>   |  | 10f. Zip Code<br><b>20815</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>librarian</b>   |  | 16b. Kind of Business/Industry<br><b>NIH</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Louis Elie Jarde'</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helene Ernestine Botiaux</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sarah T. Underwood - daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4104 Military Rd NW; Washington, DC 20015</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board</b><br><b>655 W. Baltimore St; Baltimore, MD 21201</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dysphagia</b>   |  | a. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>1 week</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Failure to thrive</b>   |  | b. Due to (or as a consequence of):   |  | <b>1 week</b>  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>End stage Dementia</b>  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>3rd nurse practitioner</b> |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>May Thomas Corp</b>  |  | 29c. License number<br><b>R113971</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 14 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>May Thomas Corp 10110 Molecular Drive #206</b><br><b>Rockville Maryland 20850</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  | 32. Registrar's Signature<br><b>Donna B. Spauld</b>   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 05575

Physician/  
Medical Examiner

Funeral  
Director

1- For State  
Registrar

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Donovan Williams</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 15, 2011</b>  |  | 3. Time of Death<br><b>1638 hrs</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Johns Hopkins Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>170-56-1935</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.   |  |
| 8. Date of Birth (MM/DD/YYYY)<br><b>10/3/71</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Queen Anne</b>  |  | 10c. City, Town or Location<br><b>Stevensville</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>600 Cloverfields Drive</b>   |  | 10f. Zip Code<br><b>21666</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  |  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  | Specify:   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouse</b>   |  | 16b. Kind of Business/Industry<br><b>Electrical</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Williams</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Kennedy</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>David LaGrossa / Brother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>803 Kimberly Way, Stevensville MD 21666</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Sepulchre Cem</b>   |  | 20c. Location - City or Town, State<br><b>Phila., PA</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 E. Fort Avenue, Baltimore MD 21230</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) <b>a. Asphyxia due to Obstruction of Airways by Foreign Body</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>d. 23a, 27, 28a-f per me g913 3-7-11 vt</b><br><b>28f per me g913 3-7-11 vt</b> |  |   |  |  |  |
| Approximate Interval Between Onset and Death  |  |   |  |  |  |
| <input checked="" type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:                 |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>2-11-11</b>  |  | 28b. Time of Injury<br><b>7:00pm</b>   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>subject put ziplock bag in mouth</b>  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>   |  | 28f. Local Address (Street and Number, City or Town, State)<br><b>706 Easton St, 900 Block Wilmott Ct, Baltimore, Md.</b>   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 16, 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05576

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kay Frances White

2. Date of Death

February 19, 2011

3. Time of Death

7:15 p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3310 Benson Avenue, Apt. 213

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

216-40-2015

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 5, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3310 Benson Avenue, Apt. 213

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Custodian

16b. Kind of Business Industry

Education

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Spindler

19a. Informant's Name/Relationship (Type, Print)

Deborah C. Stanson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2857 Louisiana Avenue, Baltimore, MD 21227

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Atlantic Crematory

Date

2-23-2011

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.  
2719 Hammonds Fry Rd., Lansdowne, MD 2122723a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. NON SMALL CELL LUNG CANCER

Approximate  
Interval Between  
Onset and Death  
1 YEAR

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

EW Cole MD

29c. License number

D16354

29d. Date signed (Month, Day, Year)

2/21/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EW COLE ST AGNES 900 CATON AVE BALTIMORE MD 21229

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

A. Spence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05577

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Homer R. Wayman

2. Date of Death

Month 2 - Day 22 - Year 11

3. Time of Death

4:55pM

4a. Facility Name (if not institution, give street and number)

501 E. Dolphin Street Apt.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

217-12-7220

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

07-26-23

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

501 E. Dolphin Street Apt.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc. African

Specify: American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chef

16b. Kind of Business Industry

B.W.I. Airport

17. Father's Name (First, Middle, Last)

Homer R. Wayman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Satterfield

19a. Informant's Name/Relationship (Type, Print)

Margie Shird-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

734 Linnard Street Baltimore, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Western Cem.

Date

03-01-11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wylie Funeral Home P.A.  
638 N. Gilmore Street Baltimore, MD 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Lung cancer with metastasis

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H0069267

29d. Date signed (Month, Day, Year)

2-23-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Karen Covatta Bowen

827 Linden Av. North MD. 21261

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

2011 05578

1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |  |  |   |  |  |  |  |   |  |  |
|---|--|--|--|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Leslie Wedgeworth</b>  |  |  |  |   |  | 2. Date of Death<br>Month <b>2</b> Day <b>13</b> Year <b>2011</b>  |  |  | 3. Time of Death<br><b>11:04 PM</b>                   |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hospital</b>  |  |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  |  | 4c. County of Death<br><b>Prince Georges</b>          |  |  |
| 5. Social Security Number<br><b>448-24-2444</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> <del>79</del> Yrs.  |  | If Under 1 Year<br>Months Days Hours Min.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 25, 1930</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b>  |  |
| Usual Residence of Decedent   |  |  |  |   |  |  |  |  |   |  |  |
| 10a. State<br><b>DC</b>   |  | 10b. County  |  | 10c. City, Town or Location   |  |  |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>505 Suffolk Ave: Apt #220</b><br><del>2817 Gainesville Street SW</del>   |  |  |  |   |  | 10f. Zip Code<br><b>20020</b> <del>20020</del> <b>20743-3016</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>           |  |  |
| 11. Marital Status<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>XX</b> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>1950-1953</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>volunteer</b>                      |  |  | 16b. Kind of Business Industry<br><b>unk</b>          |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lesley Wedgeworth</b>   |  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Muck</b>   |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Barkley - cousin</b>  |  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1814 Campbell Dr; Suitland, Maryland 20746</b> |  |  |   |  |  |
| 20a. Method of Disposition<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |  | 20c. Location - City or Town, State  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  |  |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board</b><br><b>655 W. Baltimore St; Baltimore, MD 21201</b>                                  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><br><b>c. Due to (or as a consequence of):</b><br><br><b>d. Due to (or as a consequence of):</b> |  |  |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No<br><b>9</b> <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br><b>1</b> <input type="checkbox"/> Live Birth <b>2</b> <input type="checkbox"/> Fetal death <b>3</b> <input type="checkbox"/> Ectopic pregnancy<br><b>4</b> <input type="checkbox"/> Pregnant at time of death <b>5</b> <input type="checkbox"/> Other (specify)<br><b>9</b> <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  |  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><b>3</b> <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                          |  |  |  |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Karen Brooks, MD</b>  |  |  |  |   |  | 29c. License number<br><b>00042183</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>2/13/11</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Karen Brooks 3001 Hospital Dr Cheverly MD 20785</b>  |  |  |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  |  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |   |  |  |

Baltimore, Maryland 21215-0036  
 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 05579

1- For State Registrar

Reg. No.

Physician/  
Medical Examiner

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Leland Wilkinson</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 12, 2011</b>  |  | 3. Time of Death<br><b>1535 hrs</b>  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>11206 Evans Trail #201</b>   |  | 4b. City, Town, or Location of Death<br><b>Beltsville</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |   |  |
| 5. Social Security Number<br><b>535-22-0559</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br><b>Dec 19, 1926</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Washington</b> |  |
| Usual Residence of Decedent   |  |   |  |  |   |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Prince Georges</b>   | 10c. City, Town or Location<br><b>Beltsville</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>11206 Evans Trail #201</b>   |  | 10f. Zip Code<br><b>20705</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify          |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>laborer</b>   |  | 16b. Kind of Business/Industry<br><b>steel industry</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John E. Wilkinson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Dawson</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jeanne Wilkinson - daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1625 Maria Ave; Spring Valley, CA 91977</b>   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other Specify in state  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |   |  |
| 21. Signature of Funeral Service Licenses<br><b>Ronald S. Wade, Director</b>  |  | 22. Name and Address of Facility<br><b>State Anatomy Board<br/>655 W. Baltimore St; Baltimore, MD 21201</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Cutting Wounds</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED #15 per sa, g913, 03/29/2011dhb, #1 per me |  |   |  |  | Approximate Interval Between Onset and Death                  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
|   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene    |  |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: Feb 12, 2011</b>  | 28b. Time of Injury<br><b>FOUND: 1515 hrs</b>        | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>Subject cut self</b>  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Multi-Family Apt.</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>11206 Evans Trail #201, Beltsville, MD</b>  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 13, 2011</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, per FH, G913, 3/2/2011, WS  
State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEM#19a, per INF, G913, 3/4/2011, WS  
Certificate of Death

Reg. No. 2011 05580

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, WB.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |                          |   |   |  |   |
|---|--------------------------|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>George Wheeler</b>   |                          | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>18:00p</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>   |                          |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death                                     |
| 5. Social Security Number<br><b>215-40-2642</b>   |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>1-12-1943</b> |
| 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>   |                          | 10. Usual Residence of Decedent   |   |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>na</b> | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>1002 Cecil Avenue</b>  |                          | 10f. Zip-Code<br><b>21218</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>unk</b>   |   |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b>  |                          | 16b. Kind of Business/Industry<br><b>Reese Printing Company</b>   |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>unk</b>   |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Stokes</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George Wheeler, Jr-Son</b>   |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4202 Arizona Avenue Balto, MD 21206</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt Carmel Cem</b>  |   | 20c. Location - City or Town, State<br><b>Balto, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br>   |                          | 22. Name and Address of Facility<br><b>March East F/H 1101 E. North Avenue Balto, MD 21202</b>  |   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Asystole</b><br>Due to (or as a consequence of):<br>b. <b>hyperkalemia</b><br>Due to (or as a consequence of):<br>c. <b>Acute Renal failure</b><br>Due to (or as a consequence of):<br>d. |                          |   |   |  |   |
| 23b. If female:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown                                      |                          |   |   |  |   |
| 23d. Date of delivery<br>Month Day Year   |                          |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                          |   |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                          |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                          |   |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                          |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                          |   |   |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |                          |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |                          | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                          | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                          |   |   |  |   |
| 29b. Signature and title of certifier<br>   |                          | 29c. License number<br><b>RES-000</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 18, 2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vanessa Vasquez 600 North Wolfe St, Baltimore, MD, 21287</b>   |                          |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |                          | 32. Registrar's Signature<br>   |   |  |   |

Reg. No. 2011 05581

Reg. No.

FEB 24 2011



1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAURICE WATSON

2. Date of Death

Feb 18 2011

3. Time of Death

7:09 P M

4a. Facility Name (if not institution, give street and number)

30 Hillvale Road

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-38-6374

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

8. Date of Birth

2/19/1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

30 Hillvale Road

10f. Zip Code

21228 21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sanitation Engineer

16b. Kind of Business Industry

City Government

17. Father's Name (First, Middle, Last)

Walter F. Watson

18. Mother's Name (First, Middle, Maiden Surname)

Helen E. Mulcare

19a. Informant's Name/Relationship (Type, Print)

Grace L. Watson / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 Hillvale Road, Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

2/22/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Hubbard Funeral, Inc.  
4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (specify)

9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

015872

29d. Date signed (Month, Day, Year)

Feb 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marion BCB 6934 Arlington Blvd Suite A 2106

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05583

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Joseph Philip Zacharko

2. Date of Death

Month Day Year  
2 23 2011

3. Time of Death

12 45 AM

4a. Facility Name (If not institution, give street and number)

FRANKLIN Square Hospital

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

220-18-7983

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 11, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2900 Scherer Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

NASA and Metro

17. Father's Name (First, Middle, Last)

Joseph Zacharko

18. Mother's Name (First, Middle, Maiden Surname)

Helen Stec

19a. Informant's Name/Relationship (Type, Print)

Edith Zacharko-spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2900 Scherer Avenue-Parkville, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

Feb. 26, 2011

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Evans Funeral Chapel and Cremation Services  
8800 Harford Road-Parkville, Maryland 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Pleural effusion

Due to (or as a consequence of):

c. Dysphagia

Due to (or as a consequence of):

d. [Blank]

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

1769198

29d. Date signed (Month, Day, Year)

FEBRUARY, 23, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR John KottaraThil 9000 FRANKLIN Square DR BALTO md 21237

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

zacharko Joseph P.

1041

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05584

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY LEWIS ADAMS

2. Date of Death  
Month Day Year

2-5-11

3. Time of Death  
03:30 A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

CHARLOTTE HALL VETERANS HOME

4b. City, Town, or Location of Death

CHARLOTTE HALL

4c. County of Death

ST. MARYS

5. Social Security Number

219-26-1699

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

12-27-37

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

Linthicum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

204 TWIN OAKS RD.

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates. 1955-6913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Second (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FINISH CARPENTER

16b. Kind of Business Industry

PROPERTY MANAGEMENT

17. Father's Name (First, Middle, Last)

HARRY LEWIS ADAMS

18. Mother's Name (First, Middle, Maiden Surname)

SALLIE DEVONA DAUGHERTY

19a. Informant's Name/Relationship (Type, Print)

MIRIAM TAYLOR, AUNT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

204 TWIN OAKS RD. LINTHICUM, MD. 21090

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

W. ARUNDEL CREMATORY

Date

2-10-11

20c. Location - City or Town, State

ODENTON, MD.

21. Signature of Funeral Service Licensee

J. J. Oghlin M00942

22. Name and Address of Facility

DAUGHERTY FUNERTY HOME  
2601 MOUNTAIN RD. PASADENA, MD. 2112223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause in each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Parkinson's Disease, End-Stage

Approximate  
Interval Between  
Onset and Death

Years

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lewy-Body Dementia  
Aspiration Pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas M. Annulis, MD

29c. License number

D0052401

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas M. Annulis, MD; 29449 Charlotte Hall Road; Charlotte Hall, MD 20622

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Annulis

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05585

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Arielle Dasema-Fils Aime</b>   |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>28</b> Year <b>2011</b>  |                                | 3. Time of Death<br><b>4:40 PM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Kline Hospice House</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Mount Airy</b>  |                                | 4c. County of Death<br><b>Frederick</b>  |  |
| 5. Social Security Number<br><b>218-87-8974</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>Sept. 29, 1944</b>                                | 9. Birthplace (State or Foreign Country)<br><b>Haiti</b> |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6746 Sandpiper Court</b>   |  |   |  | 10f. Zip Code<br><b>21703</b>  |                                | 10g. Citizen of What Country?<br><b>Haiti</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>   |                                | 16b. Kind of Business Industry<br><b>Clothing</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Francois Fils Aime</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname) (unk.)<br><b>Degrace</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gaby Dasema / Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6746 Sandpiper Ct. Frederick, MD 21703</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens</b>                                       |  | Date<br><b>Feb. 4, 2011</b>  |                                | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>                              |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Resthaven Funeral Services, Skkot Cody P.A.<br/>9501 Catocin Mountain Hwy. Frederick, MD 21701</b>  |                                |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. malignant - uterine adenocarcinoma.</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b>   |  |  |  | Approximate Interval Between Onset and Death<br><b>11 months.</b>   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>g <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House</b> |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>20067691</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02-01-2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mark G. Goldstein, M.D. 501 W. 7th St., Frederick, MD 21701</b>  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>   |  |  |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- AMEND #2 per PHY State of Maryland / Department of Health and Mental Hygiene  
For State Registrar 2/4/2011 ANNE ARUNDEL CO. CMH Certificate of Death

Reg. No. 2011 05586

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel F. Atwell

2. Date of Death

Month 29 Day Year Jan 30 2011

3. Time of Death

11:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Genesis HealthCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

216-70-4248

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth (Month, Day, Year)

Aug. 14, 1917

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Goldsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25630 Paradise Lane

10f. Zip Code

21636

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter Presley

18. Mother's Name (First, Middle, Maiden Surname)

Dallie Rudd

19a. Informant's Name/Relationship (Type, Print)

Donald Atwell/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25630 Paradise Lane Goldsboro, Maryland 21636

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glen Haven Mem. Park

Date

2/8/2011

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Myelin T. Klobes

22. Name and Address of Facility John M. Taylor Funeral Home

147 Duke of Gloucester St., Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Adult failure to thrive

Due to (or as a consequence of):

b. Cerebrovascular accident

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

months

years

years

Sequentially list conditions  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Crowley MD

29c. License number

725933

29d. Date signed (Month, Day, Year)

1.31.11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL CROWLEY MD 610 DUTCHMAN'S LANE EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

Denise B. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Mabel Atwell  
Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Michael Ray Bowman</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>3</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>12:40 a.m.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Moran Manor Nursing Home</b>   |  | 4b. City, Town, or Location of Death<br><b>Westernport</b>  |   | 4c. County of Death<br><b>Allegany</b>   |  |
| 5. Social Security Number<br><b>235-56-3406</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 1, 1937</b>  | 9. Birthplace (State or Foreign Country)<br><b>Keyser, WV</b>  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>WV</b>   | 10b. County<br><b>Mineral</b>  | 10c. City, Town or Location<br><b>Keyser</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>Rt. 5, Box 314</b>   |  | 10f. Zip Code<br><b>26726</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |  | 16b. Kind of Business/Industry<br><b>Poultry Processing</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Delmore Bowman</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Mae Porter</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Selenna Bowman/Daughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 5, Box 314 Keyser, WV 26726</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Queen's Point Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>2-17-11 Keyser, WV</b>   |  |
| 21. Signature of Funeral Service Licensed<br>  |  | 22. Name and Address of Facility<br><b>Smith Funeral Home<br/>85 S. Main Street Keyser, WV 26726</b>  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pancreatic Cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |
| Approximate Interval Between Onset and Death<br><b>months</b>   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus Hypertension</b>   |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D21244</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/4/2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jesus Tan, M.D. 4 Broadway Frostburg, MD 21532</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

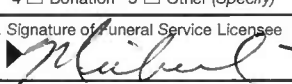
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05588

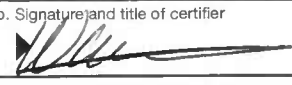
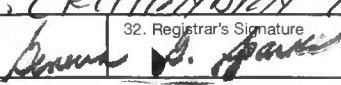
1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Delores Branham</b>  |  | 2. Date of Death<br>Month <b>02</b> Day <b>16</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>5<sup>45</sup> AM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Genesis LaPlata Ctr</b>  |  | 4b. City, Town, or Location of Death<br><b>LaPlata MD</b>   |   | 4c. County of Death<br><b>Charles</b>  |  |
| 5. Social Security Number<br><b>579-46-2628</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>1-20-1935</b>                     |  | 9. Birthplace (State or Foreign Country)<br><b>W.VA.</b> |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>MD.</b>  | 10b. County<br><b>CHARLES</b>  | 10c. City, Town or Location<br><b>LA PLATA</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1 MAGNOLIA DRIVE</b>   |  | 10f. Zip Code<br><b>20646</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)                     |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOOD SERVICE DIRECTOR</b>   |  | 16b. Kind of Business Industry<br><b>SO. MD. HOSP. CENTER CLINTON, MD</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES A. DeBOARD</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EVA MAE COLLETT</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SANDRA YEAGER-DAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>109 JENNIFER DR. INDIAN HEAD, MD. 20640</b>   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEM. GARDENS</b>   |   | 20c. Location - City or Town, State<br><b>2-19-11 WALDORF, MD.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646</b>   |   |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |
|--|--|---|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>  |  | Approximate Interval Between Onset and Death  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown    |  |
| 23d. Date of delivery<br>Month Day Year  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>INSULIN DEPENDENT DIABETES</b><br><b>HYPERTENSION</b>   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |
| 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M  |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. Signature and title of certifier<br> Physician   |  | 29c. License number<br><b>18054547</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/16/11</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM J. CRITTENDEN 7350 VAN DUSEN RD #350 LATOURE MD 20707</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  | 32. Registrar's Signature<br>  |  |

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

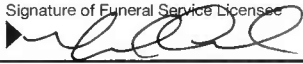
## Certificate of Death

Reg. No.

2011 05589

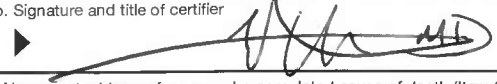

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |  |  |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Robert Berry, Jr.</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>21</b> Year <b>2011</b>   |  |   |  | 3. Time of Death<br><b>2:15 A M</b>  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>6808 Amelano Drive</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  |   |  | 4c. County of Death<br><b>Frederick</b>  |  |  |  |
| 5. Social Security Number<br><b>218-38-9168</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 6, 1941</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>                                       |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>6808 Amelano Drive</b>   |  |   |  | 10f. Zip Code<br><b>21702</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States of America</b>                                   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  |   |  | 16b. Kind of Business Industry<br><b>Trucking</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Berry, Sr.</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maxine (Unknown)</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon L. Berry / Wife</b>   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6808 Amelano Drive, Frederick, Maryland 21702</b> |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | Date<br><b>February 24, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>                                  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M01433</b>   |  |   |  | 22. Name and Address of Facility<br><b>Keeney &amp; Basford P.A. Funeral Home</b><br><b>106 East Church Street, Frederick, Maryland 21701</b>  |  |   |  |  |  |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>metastatic Squamous cell Cancer of Lung</b><br>Due to (or as a consequence of):  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>15 m.</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>Elhamy Eskander, MD</b>   |  |   |  | 29c. License number<br><b>D 48184</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/21/11</b>                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elhamy Eskander, MD 501 W 7th Street Frederick, MD 21701</b>  |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  |   |  | 32. Registrar's Signature<br> |  |  |  |  |  |

State  
Registrar

ORIGINAL

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
**amend #4b Per ME G912 2/24/2011 JB**

Robert Hector Becker

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05590

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

ROBERT HECTOR BECKER

2. Date of Death

Month Day Year  
February 15, 2011

3. Time of Death

1520 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Middleton Road / Billingsley Road

4b. City, Town, or Location of Death

Waldorf Waldorf

4c. County of Death

Charles

5. Social Security Number

219-27-2034

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

22 Yrs.

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

7-5-1988

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6410 WARREN C. ELLER DRIVE

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SHEET METAL WORKER

16b. Kind of Business/Industry

SHEET METAL WORKERS UNION

17. Father's Name (First, Middle, Last)

JOHN DANIEL BECKER

18. Mother's Name (First, Middle, Maiden Surname)

SUSAN MARIE PENROD

19a. Informant's Name/Relationship (Type, Print)

JOHN D. BECKER-FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6410 WARREN C. ELLER DR. LA PLATA, MD. 20646

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY 2-19-11

Date

20c. Location - City or Town, State

ALEX., VA.

21. Signature of Funeral Service Licensee

M00479

22. Name and Address of Facility

RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MD. 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

Feb 15, 2011

28b. Time of Injury

1515 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Local Street

28d. Describe how injury occurred

Subject shot self

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Billingsley Road / Middletown Road, Waldorf, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carol Allan

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 16, 2011

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Anna B. Sparks

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert 6913 3/17/11 dk

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2011 05591

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |
|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARYANNE BAILEY</b>  |  | 2. Date of Death<br>Month <b>01</b> Day <b>31</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>0717 AM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death  |
| 5. Social Security Number<br><b>213-44-0170</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 11, 1947</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
| Usual Residence of Decedent   |  |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>1352 N. Fremont Avenue</b>   |  | 10f. Zip Code<br><b>21217</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African-American</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bail Bondswoman</b>   |  | 16b. Kind of Business Industry<br><b>Law Enforcement</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jannis M. Bailey</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Bessix</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Angela Bailey/daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>318 Glen Ave., Apt. 204, Salisbury, MD 21801</b>  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Acres Mem Park</b>   |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>  |
| 21. Signature of Funeral Service Licensee<br><b>Lalana D. Watson</b>  |  | 22. Name and Address of Facility<br><b>Lewis N. Watson Funeral Home, PA<br/>1618 West Road, Salisbury, MD 21801</b>   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):<br>b. <b>CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>c. <b>MORBID OBESITY</b><br>Due to (or as a consequence of):<br>d.  |  |   |  | Approximate Interval Between Onset and Death<br><b>DAYS</b><br><b>YEARS</b><br><b>YEARS</b>  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ACUTE RENAL FAILURE</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br><b>M</b>                            | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Geoffrey R. Sheinfeld MD</b>  |  | 29c. License number<br><b>D66 335</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>01/31/2011</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Geoffrey R Sheinfeld MD 22 South Greene ST Baltimore MD</b>  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>   |  | 32. Registrar's Signature<br><b>Lalana D. Watson</b><br><b>2/20/11</b>  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

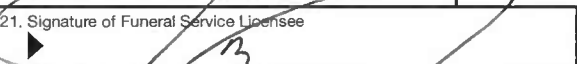
## Certificate of Death

Reg. No.

2011 05592

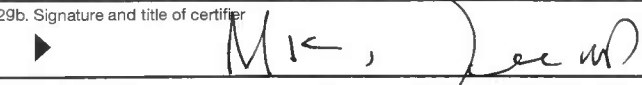
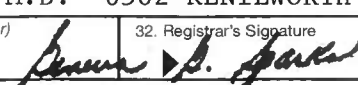
1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>FLORENCE BARBER</b>  |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>3</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>7:30 AM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>6007 CROWN STREET</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>SEAT PLEASANT</b>   |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |  |
| 5. Social Security Number<br><b>217-64-9591</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 29 1954</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>SEAT PLEASANT</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6007 CROWN STREET</b>  |  |   |  | 10f. Zip Code<br><b>20743</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>SCHOOL BUS ATTENDANT</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GOVERNMENT</b>   |  | 16b. Kind of Business Industry   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH FORD</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RUTH HARPER</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSSIE BARBER/HUSBAND</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6007 CROWN STREET SEAT PLEASANT, MARYLAND 20743</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY CEMETERY</b>   |  | Date<br><b>2/11/2011</b>   |  | 20c. Location - City or Town, State<br><b>LANDOVER, MARYLAND</b>                                   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME, INC.<br/>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>   |  |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Diabetes mellitus</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |  |  |  | Approximate Interval Between Onset and Death   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  |  |  |
| 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of injury (Month, Day, Year) _____ 28b. Time of injury _____ M _____ 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D0023125</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-7-11</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MADHU MOHAN M.D. 6502 KENILWORTH AVENUE RIVERDALE, MARYLAND 20737</b>   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>  |  |  |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2011 05593

| 1- For State Registrar   |  | Reg. No.  |  |
|--|--|---|--|
| Physician/<br>Medical Examiner   |  | 2. Date of Death<br>Month Day Year<br>February 13, 2011   |  |
| 3. Time of Death<br>1438 hrs   |  |   |  |
| 4a. Facility Name (if not institution, give street and number)<br>Washington Adventist Hospital  |  | 4b. City, Town, or Location of Death<br>Takoma Park   |  |
| 4c. County of Death<br>Montgomery  |  |   |  |
| 5. Social Security Number<br>578-04-5915   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  |
| 7. Age (In yrs. last birthday)<br>64 Yrs.  |  | 8. Date of Birth (MM/DD/YYYY)<br>JUNE 6 1946  |  |
| 9. Birthplace (State or Foreign Country)<br>NIGERIA  |  |   |  |
| Usual Residence of Decedent  |  |   |  |
| 10a. State<br>MD   |  | 10b. County<br>PRINCE GEORGE'S  |  |
| 10c. City, Town or Location<br>LANHAM  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 10e. Street and Number<br>7723 FINNS LANE  |  | 10f. Zip Code<br>20706  |  |
| 10g. Citizen of What Country?<br>USA   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4YRS   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>COMMUNICATION SPECIALIST   |  |
| 16b. Kind of Business/Industry<br>GOVERNMENT   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>BIDI KYOUNG   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>NRYANGO FUTON  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>MARGARET M. BIDI/WIFE  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7723 FINNS LANE LANHAM, MARYLAND 20706   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GATE OF HEAVEN  |  |
| 20c. Date<br>2/25/2011   |  | 20d. Location - City or Town, State<br>SILVER SPRING, MARYLAND  |  |
| 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility<br>J.B. JENKINS FUNERAL HOME, INC.<br>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785   |  |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pulmonary Emboli Complicating Hypertensive Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a,27 per me g913 3-2-11 vt |  | Approximate Interval Between Onset and Death  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Laron Locke MD. Assistant Medical Examiner   |  |
| 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>February 14, 2011  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>FEB 18 2011   |  | 32. Registrar's Signature<br>Daniel Bidi  |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05594

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Butler

2. Date of Death

Month Day Year  
02 07 2011

3. Time of Death

10 10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NMS of Hagerstown

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

578-12-3584

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 26, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington County

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12817 Little Elliott Dr. Apt. 1

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

Joseph B. Owens

18. Mother's Name (First, Middle, Maiden Surname)

Wilhelmina Elizabeth Arnold Owens

19a. Informant's Name/Relationship (Type, Print)

Michael Johns-grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1101 Sugar Maple Lane Herndon, VA 20170

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery 2-14-2011

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Kaitlin Zaffarone Sides

22. Name and Address of Facility

Douglas A. Fiery Funeral Home

1331 Eastern Blvd. North Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death Check only one

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephanie Comer-Concordia CAP

29c. License number

R125748

29d. Date signed (Month, Day, Year)

02/08/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephanie Comer-Concordia CAP 14014 Marsh Pike Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

Anne S. [Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05595

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edmund Rudolf Bauer

2. Date of Death

February 8, 2011

3. Time of Death

2:20 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

11537 Bootstrap Trail

4b. City, Town, or Location of Death

Lusby

4c. County of Death

Calvert

5. Social Security Number

219-36-9621

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/03/1940

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11537 Bootstrap Trail

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ NoIf Yes, Give Year or Dates.  
1959-1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Systems Engineer

16b. Kind of Business Industry

Nuclear Power Plant

17. Father's Name (First, Middle, Last)

Rudolf Bauer

18. Mother's Name (First, Middle, Maiden Surname)

Frieda Paulina Holder

19a. Informant's Name/Relationship (Type, Print)

Ethel Virginia Bauer - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11537 Bootstrap Trail, Lusby, Maryland 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Veterans Cemetery

Date

2-16-2011

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

S. S. S. S.

22. Name and Address of Facility

Rausch Funeral Home, P.A.

P. O. Box 600, Lusby, Maryland 20657

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SQUAMOUS CELL CANCER WITH UNKNOWN PRIMARY

Approximate Interval Between Onset and Death  
2 months

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Yes 4 ☐ No5 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, DM, COPD

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. S. S. S.

29c. License number

D36969

29d. Date signed (Month, Day, Year)

February 8, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scaria Mathew, MD 11910 H. G. Trueman Road, Lusby, Maryland 20657

31. Date filed (Month, Day, Year)

FEB - 9 2011

32. Registrar's Signature

S. S. S. S.

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

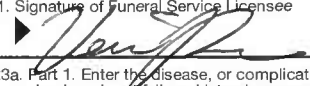
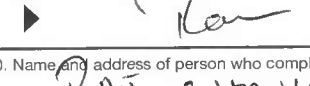

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05596

1- For State Registrar

Physician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Linda Bingham</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>4</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>5:30am</b> M  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>South River Rehab</b>   |  | 4b. City, Town, or Location of Death<br><b>Edgewater</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>218-56-9940</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 18, 1949</b>                  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Gambrills</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>2503 Symphony Lane</b>  |  | 10f. Zip Code<br><b>21054</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Seconday (0-12) <b>1</b> College (1-4 or 5+)  |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Logistics</b>  |  | 16b. Kind of Business Industry<br><b>NASA</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Phillips</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret unknown</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dale Bingham / Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7426 Danbridge Lane, Owings, MD 20736</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Mem. Park</b>   |  | 20c. Location - City or Town, State<br><b>2/9/2011 Falls Church, VA</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Beall Funeral Home<br/>6512 NW Crain Hwy, Bowie MD. 20715</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cirrhosis of the liver</b><br>Due to (or as a consequence of):<br><b>due hepatitis C</b>  |  |   |  |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. Due to (or as a consequence of):</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DQA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)        |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)<br><b>M</b>  |  | 28b. Time of injury<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0053709</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 7th 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DALE BINGHAM 14300 Gallant Fox Lane Ste # 216 Bowie MD</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 2011</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05597

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RONALD L. BROWN SR.

2. Date of Death

01 25 2011

3. Time of Death

2356 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

216-60-5674

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec 15 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29 West Washington St. #503

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Furniture Mover

16b. Kind of Business Industry

Earle's Moving &amp;

Storage

17. Father's Name (First, Middle, Last)

Freddie Brown Sr

18. Mother's Name (First, Middle, Maiden Surname)

Alice V. Thomas

19a. Informant's Name/Relationship (Type, Print)

Ronald Brown Jr (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

817 Chestnut Tree Dr. Annapolis, Md. 21403

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

2-3-11

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Larry H. Brown 00083

Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.  
821 West St. Annapolis, Md. 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death  
MONTHS

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Lentz MD

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

January 26 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LENTZ MD 445 DEFENSE HWY ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Anna B. Spaw

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05598

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel Randolph Brown Sr

2. Date of Death

January 30 2011

3. Time of Death

3:30 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

5204 Nick Rd.

4b. City, Town, or Location of Death

Shady Side

4c. County of Death

Anne Arundel

5. Social Security Number

220-56-8023

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 22 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Shady Side

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5204 Nick Rd.

10f. Zip Code

20764

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1971-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business Industry

Entrepreneur

17. Father's Name (First, Middle, Last)

Guy L. Brown Sr

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Brooks

19a. Informant's Name/Relationship (Type, Print)

Pamela A. Brown (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5204 Nick Rd. Shady Side, Md. 20764

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veteran

Date

2-4-11

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

Larry H. Reese

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.  
821 West St. Annapolis, Md. 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

b. Diabetes

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. Jones, MD Deputy

29c. License number

D06054

29d. Date signed (Month, Day, Year)

2/4/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD, 695 America 21035

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Anna B. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05599

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LONNIE C

BROWN

2. Date of Death  
Month Day Year

FEB 02 02 2011

3. Time of Death

1404PM

4a. Facility Name (if not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-30-7309

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

MAY 28, 1938

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

BOWIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16903 ASPEN LEAF COURT

10f. Zip Code

20716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MAINTENANCE WORKER

16b. Kind of Business Industry

MAINTENANCE

17. Father's Name (First, Middle, Last)

JOHN H. BROWN, SR.

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE R. HERNDON

19a. Informant's Name/Relationship (Type, Print)

GLORIA J. BROWN/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16903 ASPEN LEAF COURT, BOWIE, MD 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)BESTGATE MEMORIAL  
PARK

Date

02/08/2011

20c. Location - City or Town, State

ANNAPOLIS, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LASTING TRIBUTES BY FELLOWS  
HELFFENBEIN & NEWSAM CREMATION & FUNERAL CARE, P.A.  
814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. INTERSTITIAL LUNG DISEASE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. NON-ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

YEAR (ONE)

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Prostate Cancer,  
Asbestos Exposure, Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

149791624  
P25740

29d. Date signed (Month, Day, Year)

02/08/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK BUCHT 22 S. GREENE ST BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05600

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

KATHERINE BLEVINS

2. Date of Death

Month Day Year

JAN 31 2011

3. Time of Death

8:05A M

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home and Rehab. Center

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

213-14-1693

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

8. Date of Birth (Month, Day, Year)

August 7, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Jessup

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8945 Madison Street

10f. Zip Code

20794

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

John's Hopkins Lab.

17. Father's Name (First, Middle, Last)

Harry R. Klotz

18. Mother's Name (First, Middle, Maiden Surname)

Edith Pearl Bradley

19a. Informant's Name/Relationship (Type, Print)

Wayne Luyster- SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8945 Madison St., Jessup, Maryland 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Denton Cemetery

Date

Feb. 4, 2011

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee

MPgh MD1234

22. Name and Address of Facility

Fleck Funeral Home, Inc.  
7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. BACTEREMIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Spoke MD

D0053150

JAN 31 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shakunmale puyte 9650 sentigo Rd Suite 110 MD  
Columbia 2045

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Annon B. Spoke

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1- For  
State  
Registrar

2011 05601

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARLTON E. BOYLE

2. Date of Death

FEBRUARY 6, 2011

3. Time of Death

1:50 AM

4a. Facility Name (if not institution, give street and number)

714 FOX MEADOW ROAD

4b. City, Town, or Location of Death

QUEEN ANNE

4c. County of Death

QUEEN ANNE

Funeral  
Director

5. Social Security Number

216-56-2046

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth

DEC. 3, 1954

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE

10c. City, Town or Location

QUEEN ANNE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

714 FOX MEADOW ROAD

10f. Zip Code

21657

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
-0-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FARMER

16b. Kind of Business Industry

SEED PROCESSING

17. Father's Name (First, Middle, Last)

THOMAS I. BOYLE

18. Mother's Name (First, Middle, Maiden Surname)

SARAH ELIZABETH DULIN

19a. Informant's Name/Relationship (Type, Print)

MARGARET BOYLE/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

714 FOX MEADOW ROAD, QUEEN ANNE, MD 21657

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)CHESAPEAKE CREMATION  
CENTER

Date

FEB. 8,  
2011

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

ST R

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.  
408 S. LIBERTY ST., CENTREVILLE, MD 21617Physician/  
Medical  
Examiner23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

PANCREATIC CANCER

b. Due to (or as a consequence of):

DIABETES

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5/2010

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION  
Dyslipidemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

PATRICIA BOWYER MD

29c. License number

D0056076

29d. Date signed (Month, Day, Year)

02/07/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA BOWYER MD 202 COURSEVALL DRIVE, CENTREVILLE, MD 21617

31. Date filed (Month, Day, Year)

FEB - 7 2011

32. Registrar's Signature

A. B. [Signature]

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05602

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dawn E. Barfield

2. Date of Death

Month Day Year  
February 5, 2011

3. Time of Death

6:15 P. M

4a. Facility Name (If not institution, give street and number)

Glade Valley Nursing Home

4b. City, Town, or Location of Death

Walkersville

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

258-36-3567

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 30, 1927

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3433 Livingston Drive

10f. Zip Code

21755

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Administrative officer

16b. Kind of Business Industry

Federal Government

17. Father's Name (First, Middle, Last)

William Austin Eason

18. Mother's Name (First, Middle, Maiden Surname)

Lucile Gunnin

19a. Informant's Name/Relationship (Type, Print)

Dawn Duggan - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3433 Livingston Drive, Jefferson, Maryland 21755

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

2-9-2011

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Sharon Camille Cleve

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Dementia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

High blood pressure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ D.O.A.Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Helen Nelson

29c. License number

D51643

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

65c Thomas Johnson Dr Frederick MD 21702

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Helen Nelson

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05603

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marian E. Bush</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>9:45 A M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Northampton Manor</b>   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>   |  |
| 5. Social Security Number<br><b>214-01-0651</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept 26, 1914</b>  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |
| Usual Residence of Decedent  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Frederick</b>   |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>200 East 16th Street</b>  |  | 10f. Zip Code<br><b>21701</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                          |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>Own home</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Leo V. Barry</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy B. Byrd</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Frank Bush, Jr. - son</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8560 Rocky Springs Road, Frederick, Maryland 21702</b> |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stauffer Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Sharon Camille Line</i>  |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Home<br/>1621 Opossumtown Pike, Frederick, Maryland 21702</b>  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Alzheimer's Dementia</b>  |  |  |  |   |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |  |  |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Gene Ashe M.D.</i>   |  | 29c. License number<br><b>31058</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/7/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gene Ashe, M D 10200 Coppermine Road, Woodsboro, Maryland 21798</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 2011</b>  |  | 32. Registrar's Signature<br><i>Anna D. Spaw</i>   |  |   |  |

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

ORIGINAL

1- For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Trimble Bowen

2. Date of Death  
Month January Day 27, 2011 Year

3. Time of Death  
3:45 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

4509 Route 18 Main Street

4b. City, Town, or Location of Death

Grasonville

4c. County of Death

Queen Anne

5. Social Security Number

234-56-0934

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
27/15/1938

9. Birthplace (State or Foreign Country)

West VA.

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Grasonville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

P.O. Box 201 4509 Rte 18 Main Street

10f. Zip Code

21638

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Second (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business Industry

Lumber

17. Father's Name (First, Middle, Last)

Herbert Bowen

18. Mother's Name (First, Middle, Maiden Surname)

Cora Carter

19a. Informant's Name/Relationship (Type, Print)

Dorothy Bowen Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 201 4509 Rte 18 Main Street 21638 Grasonville, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial

Date

1/31/2011

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

Baldy

22. Name and Address of Facility

Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic prostate cancer

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy  
1 ☐ Live Birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

3 ☐ Ectopic pregnancy

23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David H Smith

29c. License number

D39887

29d. Date signed (Month, Day, Year)

01/28/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H Smith, MD - 100 Braemar St, Suite 117, Chester town, MD 21613

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

Anna S. Spivey

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05605

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Lee Blazewitz

2. Date of Death

January 30 2011

3. Time of Death

1:06 A M

4a. Facility Name (if not institution, give street and number)

Berlin Nursing Home

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

577-20-5075

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

August 21, 1922

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

25 Tail of the Fox Drive

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Agent

16b. Kind of Business Industry

Insurance

17. Father's Name (First, Middle, Last)

Cyrus Cary Jones

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Pauline Young

19a. Informant's Name/Relationship (Type, Print)

Debra L. Winegar / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1239 Rossback Road, Davidsonville, MD 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

2/8/2011

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A. Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. **Advanced Alzheimer's**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

R 135131

29d. Date signed (Month, Day, Year)

January 31, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennie Savage, CRNP 9715 Healthway Dr, Berlin, MD 21811

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Blazewitz, Nancy  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05606

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eric Pope Blackman

2. Date of Death

January 28, 2011

3. Time of Death

0030 M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

579-74-1582

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 4, 1955

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 69th Place

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: African  
American15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Information Technology

16b. Kind of Business Industry

Private

17. Father's Name (First, Middle, Last)

Edson E. Blackman Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris Pope

19a. Informant's Name/Relationship (Type, Print)

Devin Blackman - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8150 Lakecrest Drive # 503 Greenbelt, Md. 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Heritage

Date

February 8, 2011

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

John A. Stewart

22. Name and Address of Facility

Stewart Funeral Home, Inc.

4001 Benning Road NE Washington, DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis  
Due to (or as a consequence of):b. metabolic Acidosis  
Due to (or as a consequence of):c. Disseminated Intravascular Coagulation  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Boyce

29c. License number

D0043662

29d. Date signed (Month, Day, Year)

February 2, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyce Prince Georges Hospital 3001 Hospital Drive Cheverly Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Anna A. Parks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05607

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN

CLARKE

2. Date of Death

February 5, 2011

3. Time of Death

8:57 A M

4a. Facility Name (if not institution, give street and number)

Agape Assisted Living Facility

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

579-20-7644

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth

Nov. 23, 1920

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3607 Austin Street SE

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify: African  
American15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business Industry

Private

17. Father's Name (First, Middle, Last)

Norman Henry Hedgeman

18. Mother's Name (First, Middle, Maiden Surname)

Lena Hutchinson

19a. Informant's Name/Relationship (Type, Print)

Debra Johnson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5400 Auth Road # 536 Camp Springs, Maryland 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln

Date

February 10, 2011

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Stewart Funeral Home, Inc.

4001 Benning Road NE Washington, DC 20019

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

ADVANCED DEMENTIA

b. Due to (or as a consequence of):

ALZHEIMER'S DISEASE

c. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
g ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION  
HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted Living

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0063145

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARVIND DESAI 705 DIGITAL DR. LINTHICUM

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05608

1- For State Registrar

Physician/  
Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
Dorothy A. Crooks2. Date of Death  
Month Day Year  
February 9 20113. Time of Death  
11:45 P MFuneral  
Director

4a. Facility Name (if not institution, give street and number)

BALTIMORE WASHINGTON MEDICAL CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

515-07-1233

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

90

8. Date of Birth

03-23-1920

9. Birthplace (State or Foreign)

OKLAHOMA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1050 5th Street

10f. Zip Code

21060

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business Industry

Clerical

17. Father's Name (First, Middle, Last)

Charles Yager

18. Mother's Name (First, Middle, Maiden Surname)

Abigale Kiff

19a. Informant's Name/Relationship (Type, Print)

Jane Darroch (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1050 5th Street, Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gdns

Date

02-12-2011

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Home Licensee

[Signature]

22. Name and Address of Facility

Zellman Funeral Home, P.A. 21078

123 S. Washington Street, Havre de Grace, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. COLIC

Due to (or as a consequence of):

b. ACUTE RENAL FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 45149

29d. Date signed (Month, Day, Year)

February 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABAYO 301 Hospital Drive Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

[Signature]

State  
Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2011 05600

|  |   |  |  |   |  |  |  |  |
|--|---|--|--|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner      | 1. Decedent's Name (First, Middle, Last)<br><b>Susan Jane Nugent Coddington</b>   |  |  |   | 2. Date of Death<br>Month <b>Feb.</b> Day <b>12</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>1:05A</b> M   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Oakland Nursing &amp; Rehab. Center</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>Oakland</b>   |  | 4c. County of Death<br><b>Garrett</b>  |  |
| Funeral<br>Director                    | 5. Social Security Number<br><b>213-44-2071</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>3/23/1914</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Garrett</b>  |  | 10c. City, Town or Location<br><b>Friendsville</b>   |  |
| To Be Completed by<br>Funeral Director | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>270 Nugent Lane</b>   |   | 10f. Zip Code<br><b>21531</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   | 16b. Kind of Business Industry<br><b>Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Alfred</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Nugent/ Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>32 Nugent Lane, Friendsville, MD 21531</b>   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sand Springs Cem.</b>   |   | 20c. Date<br><b>2/15/2011</b>  |  | 20d. Location - City or Town, State<br><b>Friendsville, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Newman Funeral Homes P.A.</b>   |   | 22. City, Town, or Location<br><b>943 Second Ave., Friendsville, MD 21531</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Advanced Alzheimer's Disease</b> |  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Degenerative lumbar spine disease</b> |   | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
|  | 23e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 23f. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 23g. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 23h. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|  | 24a. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                |  | 24b. Date of injury (Month, Day, Year)<br><b></b>  |   | 24c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24d. Describe how injury occurred<br><b></b>   |  |
|  | 24e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b></b>   |  | 24f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>  |   | 24g. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 24h. Signature and title of certifier<br>  |  |
| 24i. License number<br><b>D15333</b>   |   | 24j. Date signed (Month, Day, Year)<br><b>2/16/11</b>    |  | 24k. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Thomas Johnson 311 N. Fourth St., Oakland, MD 21550</b> |  | 24l. Date filed (Month, Day, Year)<br><b>FEB 16 2011</b> |  |  |
| 24m. Registrar's Signature<br>         |   | 24n. Date filed (Month, Day, Year)<br><b>FEB 16 2011</b> |  | 24o. Registrar's Signature<br>  |  | 24p. Date filed (Month, Day, Year)<br><b>FEB 16 2011</b> |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05610

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |  |
|---|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Daniel Edward Callis</b>   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>14</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>18:15 P M</b>   |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Garrett Co. Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Oakland</b>  |   | 4c. County of Death<br><b>Garrett</b>  |  |  |
| 5. Social Security Number<br><b>220-38-2371</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 20 1941</b>                          | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |  |
| 10a. State<br><b>MD.</b>  | 10b. County<br><b>Garrett</b>  | 10c. City, Town or Location<br><b>Oakland</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>702 Boy Scout Road</b>   |  | 10f. Zip Code<br><b>21550</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1963</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) <b>1 year</b>   |   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Technician</b>  |  | 16b. Kind of Business/Industry<br><b>Verizon</b>  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Daniel Callis</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Lee Ann Dowling</b> |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Beverly E. White-Callis</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>702 Boy Scout Rd. Oakland, MD. 21550</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>White Church Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Oakland, MD.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>D.A. Burdock</b>  |  | 22. Name and Address of Facility<br><b>D.A. Burdock Funeral Home, P.A.<br/>21N. 2nd. St. Oakland, MD. 21550</b>   |   |  |  |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEPSIS</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  | Approximate Interval Between Onset and Death<br><b>days</b>  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Localized pleural effusion, pericarditis, COPD, DM2, Rheumatoid Arthritis</b>  |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)            |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D0061501</b>   | 29d. Date signed (Month, Day, Year)<br><b>2/14/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ken R. Buczycki, MD 311 N. 4th St. Suite 1 Oakland MD 21550</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 16 2011</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |

10  
+ YAState  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, this Medical Exam must be conducted at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Callis, Daniel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05611

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel C. Chase, Sr.

2. Date of Death

February 03 2011

3. Time of Death

10:35 AM

4a. Facility Name (if not institution, give street and number)

Heritage Harbour Health &amp; Rehab. Ctr.

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

312-09-8679

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
2/16/1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3535 Patuxent River Rd.

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Rigger

16b. Kind of Business Industry

Federal Government

17. Father's Name (First, Middle, Last)

Cornelius Chase

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Campbell

19a. Informant's Name/Relationship (Type, Print)

Robert H. Chase/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2857 Davidsonville Rd., Davidsonville, MD 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Cemetery

Date

2/7/11

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility George P. Kalas Funeral Home  
2973 Solomons Island Road, Edgewater, MD 21037Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Dementia Severe

b. HTN

c.

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D0070693

29d. Date signed (Month, Day, Year)

02-03-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED MAHBOOB

Tideewater colony Drive  
Suite 1-A Annapolis MD 21401

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05612

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ellen Cummings

2. Date of Death

February 6, 2011

3. Time of Death

1:25P. M

4a. Facility Name (if not institution, give street and number)

14417 Motters Station Rd.

4b. City, Town, or Location of Death

Rocky Ridge

4c. County of Death

Frederick

5. Social Security Number

236-28.3857

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

8. Date of Birth

08/20/1919

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Rocky Ridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14417 Motters Station Rd.

10f. Zip Code

21778

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

stenographer

16b. Kind of Business Industry

government

17. Father's Name (First, Middle, Last)

Powell E. Reynolds

18. Mother's Name (First, Middle, Maiden Surname)

Ethel B. Burdette

19a. Informant's Name/Relationship (Type, Print)

Karen L. Smith-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Golf Course Lane, Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Mem. Gardens

Date

02/09/11

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.  
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Atherosclerosis

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure  
Diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be determined  
4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17549

29d. Date signed (Month, Day, Year)

2/8/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Harper, MD 100 S Center St., Thurmont, MD 21788

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Reg. No. 2011 05613

Reg. No.

3. Time of Death 11:23 M

9. Birthplace (State or Foreign Country)  
Charles Cty. Md.

FEB 04 2011

DHMH 17 Rev 7/2009

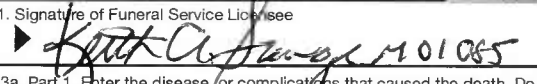
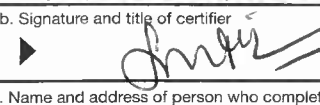
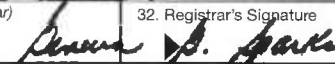
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05614

1- For  
State  
Registrar

|   |   |   |   |  |   |  |   |  |  |
|---|---|---|---|--|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Cyprians Oliver Colbert</b>  |   |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>28</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>18:20</b> M                                      |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Prince Georges Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  | 4c. County of Death<br><b>Prince Georges</b>                            |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-52-9154</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 18, 1939</b>            |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Landover</b>                          |  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |  | 10e. Street and Number<br><b>1778 Dutch Village Dr.</b>   |  |   |  |  |
|   | 10f. Zip Code<br><b>20785</b>   |   |   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>   |  | 16b. Kind of Business Industry<br><b>Private</b>  |  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Frederick Colbert</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Edell Middleton</b>  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores Butler Colbert / wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1326 W. Street N.E. Washington, D.C. 20018</b>  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet</b>   |  | Date<br><b>Feb. 5, 2011</b>   |  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>          |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Alexander S. Pope, P.A.</b><br><b>5538 Marlboro Pike / Forestville, Md. 20747</b>  |  |   |  |   |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>cardiopulmonary arrest</b><br>Due to (or as a consequence of):<br>b. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>c. <b>Acute brainstem stroke</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |   | Approximate Interval Between Onset and Death |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year                                 |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |
| 28d. Describe how injury occurred   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one) 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>D71091</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>1/28/2011</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Samreen H. Kuan, 3001 Hospital Drive, Cheverly, MD</b>   |   |   |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>   |   | 32. Registrar's Signature<br>  |   |  |   |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

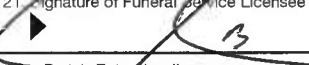
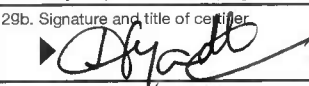

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05615

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>WILBER H. CHILDS</b>  |  |   |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>26</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>7:19 P M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>  |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |  |
| 5. Social Security Number<br><b>227-14-3205</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 3 1919</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |  |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>BLADENSBURG</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>5999 EMERSON #710</b>   |  |   |  | 10f. Zip Code<br><b>20710</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ENGINEER DEPARTMENT</b>  |  | 16b. Kind of Business Industry<br><b>PRIVATE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES CHILDS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELEN WORMLEY</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>NADINE C. BROWN/CARETAKER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13507 VANDIVER COURT UPPER MARLBORO, MARYLAND 20774</b>                                      |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FT. LINCOLN CEMETERY</b>   |  | Date<br><b>2/3/2011</b>  |  | 20c. Location - City or Town, State<br><b>BRENTWOOD, MARYLAND</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME, INC.<br/>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>   |  |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>FATAL CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>SEVERE HYPOTENSION</b><br>Due to (or as a consequence of):<br><b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):   |  |   |  |  |  |  |  |
| Approximate Interval Between Onset and Death   |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LOWER GASTRO INTESTINAL BLEEDING</b><br><b>METASTATIC COLON CANCER</b><br><b>CONGESTIVE HEART FAILURE</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br> M.D.  |  |   |  | 29c. License number<br><b>021883</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/29/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hema Pyadle M.D., 9470 ANNAPOLIS RD. SUITE 315, LANHAM, M.D 20706</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

3  
12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05616

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Garfield Cornish, Sr.

2. Date of Death

Jan. 30, 2011

3. Time of Death

8:20 P<sup>M</sup>

4a. Facility Name (if not institution, give street and number)

Hospice of Queen Anne's

4b. City, Town, or Location of Death

Centreville

4c. County of Death

Queen Anne's

5. Social Security Number

219-077693

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9-15-1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Grasonville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 Wilson Road

10f. Zip Code

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business Industry

Own Business

17. Father's Name (First, Middle, Last)

Ave Cornish

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Kiah

19a. Informant's Name/Relationship (Type, Print)

Pam Cornish

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

530 N. Vodges Street Phila. Pa. 19131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bryan's Cemetery

Date

2/5/11

20c. Location - City or Town, State

Grasonville, MD

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

Henry Funeral Home, P.A.  
510 Washington St Cambridge, MD. 21613

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prostate Cancer

Due to (or as a consequence of):

b. Anemia

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joel H. Wilkerson

29c. License number

D0027055

29d. Date signed (Month, Day, Year)

2/01/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel H. Wilkerson, M.D. 204 Medical Center Rd. Grasonville, Md. 21638

31. Date filed (Month, Day, Year)

FEB 03 2011

32. Registrar's Signature

Linda A. Smith

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05617

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PENNY GILES DONALDSON

2. Date of Death  
Month Day Year

1 31 2011

3. Time of Death

9:29 PM

4a. Facility Name (If not institution, give street and number)

Coastal Hospice at the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

279-36-5152

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

6-6-1939

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

BIVALVE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3563 WINDMILL HILL RD

10f. Zip Code

21814

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

REALTOR

16b. Kind of Business Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

JAMES E GILLES

18. Mother's Name (First, Middle, Maiden Surname)

RUTH BELL

19a. Informant's Name/Relationship (Type, Print)

JAMES DONALDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3563 WINDMILL HILL RD BIVALVE, MD 21814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SALSBURY crematory

Date

2-4-11

20c. Location - City or Town, State

SALSBURY, MD

21. Signature of Funeral Service Licensee

James J. King

MO0295

22. Name and Address of Facility

Hinman Funeral Home, PA

11673 Somerset Avenue, Princess Anne, Md. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
cause or condition  
resulting in death)

a. MAGNANT LUNG CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

00058410

29d. Date signed (Month, Day, Year)

02/01/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William W. P. 1500 1733 SALSBURY MD 21802

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

[Signature]

Penny G. Donaldson  
Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05618

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

|   |                                 |  |  |  |   |
|---|---------------------------------|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Garrett Blaise Dawson</b>  |                                 | 2. Date of Death<br>February 5 2011  |  | 3. Time of Death<br>20:40 PM   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>   |                                 | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death  |   |
| 5. Social Security Number<br><b>UNK</b>   | 6. Sex<br><b>1</b> M <b>2</b> F | 7. Age (In yrs. last birthday)<br>Yrs. <b>7</b> 4  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 5, 2011</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent   |                                 | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Dorchester</b>   |   |
| 10c. City, Town or Location<br><b>Wingate</b>   |                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2160 Wingate Bishopsgate</b>  |   |
| 10f. Zip-Code<br><b>21675</b>   |                                 | 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |   |
| 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>11/12</b>  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>n/a</b>  |  | 16b. Kind of Business/Industry<br><b>n/a</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Andrew Sherman Dawson</b>   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Shea Wheatley</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Andrew Sherman Dawson</b>  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2160 Wingate Bishopsgate Rd, Wingate MD 21675</b>  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mid Shore C.C. &amp; B. Funeral Home, Cambridge, MD</b>   |  | 20c. Location - City or Town, State<br><b>Cambridge, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br><b>Curran Bromberg</b>   |                                 | 22. Name and Address of Facility<br><b>Curran Bromberg Funeral Home, P.A., 38 High St, Cambridge, MD 21613</b>   |  |  |   |
| 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Trisomy thirteen</b><br>Due to (or as a consequence of):<br><b>b. Respiratory distress</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                 | Approximate Interval Between Onset and Death   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |                                 | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                                 |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |                                 | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                 | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                 | 29a. Certifier (check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. Signature and title of certifier<br><b>Jessica Clarke-Pounder MD</b>   |                                 | 29c. License number<br><b>RES-000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 5, 2011</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jessica Clarke-Pounder</b><br><b>600 North Wolfe St, Baltimore, MD, 21287</b>  |                                 |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 17 2011</b>   |                                 | 32. Registrar's Signature<br><b>Adam B. Gane</b>   |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05619

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Laura Brenda Davis

2. Date of Death

Month Day Year  
02 02 2011

3. Time of Death

10:03 AM

4a. Facility Name (if not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

220-68-8391

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Mos.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

7-23-1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30562 Skipjack Circle

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Environmental Services Leader

16b. Kind of Business Industry

Environmental Services

17. Father's Name (First, Middle, Last)

Roy F. Cranfield

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Holston

19a. Informant's Name/Relationship (Type, Print)

Nichole Walker - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

32427 Mt. Pleasant Road, Laurel, Delaware 19956

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Pk. 2-8-2011

Date

20c. Location - City or Town, State

Salisbury, Maryland

21. Signature of Funeral Service Licensee

Denio Kelly Parker

22. Name and Address of Facility

Bounds Funeral Home  
705 E. Main Street, Salisbury, Maryland 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

ASCD

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Thimmarayappa MD

29c. License number

D60515

29d. Date signed (Month, Day, Year)

2/3/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. THIMMARAYAPPA 910 EASTERN SHORE DR, SALISBURY MD 21804

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Anna S. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10 md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05620

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bennie Davis III

2. Date of Death  
Month Day Year

02 07 2011

3. Time of Death  
2047 PMFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

579-76-4670

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

JAN. 04 1958

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2906 Kingsway Road

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Computer Tech.

16b. Kind of Business Industry

Computers

17. Father's Name (First, Middle, Last)

Bennie Davis JR.

18. Mother's Name (First, Middle, Maiden Surname)

Delores Yeager

19a. Informant's Name/Relationship (Type, Print)

Sharon Brown-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2906 Kingsway Rd., Ft. Washington, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Pk

Date

2/15/2011

20c. Location - City or Town, State

Hyattsville, MD

21. Signature of Funeral Service Licensee

Sharon I. Napper

MO1576

22. Name and Address of Facility

5625 Allentown Rd., Camp Springs, MD 20746

Eternal Faith Funeral Service

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Cirrhosis of the Liver

b. Due to (or as a consequence of):

Hepatic Coma

c. Due to (or as a consequence of):

Hepatic Encephalopathy

d. Due to (or as a consequence of):

Renal failure

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dorothy Jackson MD

29c. License number

H0058218

29d. Date signed (Month, Day, Year)

2/19/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 St Patrick Ave Waldorf MD Suite 502 20603

Dorothy J. Jackson MD

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Dorothy J. Jackson

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05621

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marco A. DeCesaris, Jr.

2. Date of Death

Month  
02Day  
06Year  
2011

3. Time of Death

12:47 a<sup>m</sup>

4a. Facility Name (if not institution, give street and number)

3508 Enterprise Road

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-30-9234

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

8. Date of Birth

If Under 1 Year  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
01/29/1927

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3508 Enterprise Road

10f. Zip Code

20721

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Real Estate Broker

16b. Kind of Business Industry

Commercial Land Specialist

17. Father's Name (First, Middle, Last)

Marco A. DeCesaris, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ida Janetti

19a. Informant's Name/Relationship (Type, Print)

Albert DeCesaris / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3930 Park Place, Huntingtown, MD 20639

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resurrection Cemetery

Date

02/22/2011

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Gary J. Goff

22. Name and Address of Facility Lee Funeral Home Calvert, P.A.

8125 Southern Maryland Blvd., Owings, MD 20736

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Metastatic Lung Cancer

Due to (or as a consequence of):

b. Hypertensive Cardiovascular disease

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rakesh Arora MD

29c. License number

D20108

29d. Date signed (Month, Day, Year)

2/18/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, MD, 14300 Gallant Fox Ln, Ste 222, Bowie, MD 20715

31. Date filed (Month, Day, Year)

FEB - 9 2011

32. Registrar's Signature

Lorena B. Spivey

State  
RegistrarBaltimore, Maryland 21215-0036  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05622

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vera Mildred Day

2. Date of Death

Month Day Year  
January 31 2011

3. Time of Death

4:00 A M

4a. Facility Name (if not institution, give street and number)

10422 Shady Acres Lane

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

214-28-3864

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 7, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10422 Shady Acres Lane

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter G. Whitehead

18. Mother's Name (First, Middle, Maiden Surname)

Viola Green

19a. Informant's Name/Relationship (Type, Print)

Linda L. Kveseth - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5063 Netherstone Court, Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Emmanuel UMC Cemetery

Date

02/03/2011

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

[Signature] MD1283

22. Name and Address of Facility

Fleck Funeral Home, Inc.  
7601 Sandy Spring Road, Laurel, Maryland 2070723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cirrhosis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
2008

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] CRNP

29c. License number

R125808

29d. Date signed (Month, Day, Year)

1-31-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anne Lewis Villanueva, CRNP  
6701 N. Charles St., Ste 4105, Baltimore, MD 21204

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05623

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Howard Doyle</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>4</b> Year <b>2011</b>  |                                | 3. Time of Death<br><b>8:45A M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Lorien of Mount Airy</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Mount Airy</b>  |                                | 4c. County of Death<br><b>Carroll</b>  |  |
| 5. Social Security Number<br><b>217-28-5344</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 21, 1931</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Mount Airy</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1008 Merridale Boulevard</b>   |  |   |  | 10f. Zip Code<br><b>21771</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Management Analyst</b>   |                                | 16b. Kind of Business Industry<br><b>U.S. Government</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Sylvester Doyle</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Mc Clane</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>June M. Doyle - Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21771</b><br><b>1008 Merridale Boulevard, Mount Airy, Maryland</b>                          |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pine Grove Cemetery</b>  |  | Date<br><b>02/10/2011</b>  |                                | 20c. Location - City or Town, State<br><b>Mount Airy, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>  |  |   |  | 22. Name and Address of Facility<br><b>Molesworth-Williams P.A., Funeral Home</b><br><b>26401 Ridge Road, Damascus, Maryland 20872</b>   |                                |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Viral pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Parkinsons Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>   |  |   |  |  |                                |  |  |
| Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>10 yrs</b>  |  |   |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |  |                                | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |                                | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>John Middleton MD</b>   |  |   |  | 29c. License number<br><b>D25443</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>February 7, 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Middleton, M.D. 688 Poole Road, Westminster, Maryland 21157</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 2011</b>   |  |   |  | 32. Registrar's Signature<br><b>James B. Jones</b>   |                                |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05624

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Robert DeMar

2. Date of Death

January 31 2011

3. Time of Death

1:06 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

577-44-1384

6. Sex

XX M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 18, 1933

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11601 Terrace Drive

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Western Electric

17. Father's Name (First, Middle, Last)

Charles Edgar DeMar

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Bivens

19a. Informant's Name/Relationship (Type, Print)

Michael DeMar / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11601 Terrace Drive Waldorf, Maryland 20602

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Vet. Cem.

Date

02/10/2011

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home PA  
6160 Oxon Hill Rd. Oxon Hill, Maryland 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Prostate Cancer

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Collins P. Seim

29c. License number

D46979

29d. Date signed (Month, Day, Year)

2/11/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Collins P. Seim, 3460 Old Washington Road, Waldorf MD 20602

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

Denise S. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Charles Demar M/26503  
Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05625

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN WILLIAM EURY</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>14</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>10:25 P M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>   |  | 4c. County of Death<br><b>FREDERICK</b>  |  |
| 5. Social Security Number<br><b>215-42-3891</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>October 2, 1946</b>  | 9. Birthplace (State or Foreign Country)<br><b>Frederick</b>   |  |
| Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Frederick</b>  | 10c. City, Town or Location<br><b>Brunswick</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>209 East Patomac Street</b>  |  | 10f. Zip Code<br><b>21716</b>  |  | 10g. Citizen of What Country?<br><b>United States of America</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1964-1970</b><br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Customer Service</b>               |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Customer Service</b>  |  | 16b. Kind of Business Industry<br><b>Welding</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William H. Eury</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kathleen I. Bittle</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy A. Eury / Wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>209 East Patomac Street, Brunswick, Maryland 21716</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Grace Reformed Church Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>February 18, 2011</b><br><b>Knoxville, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Keeney &amp; Basford P.A. Funeral Home</b><br><b>106 East Church Street, Frederick, Maryland 21701</b>                      |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>coronary artery disease</b>  |  |  |  |  |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Diabetes mellitus, Hypertension, Hyperlipidemia, obesity</b> |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>  |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D47169</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/15/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHAN-HING HO, MD. 610 9th AVE, BRUNSWICK, MD 21716</b>   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 20b,c per 11 g 912 2-24-11 vt

State of Maryland / Department of Health and Mental Hygiene

2011 05626

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Mae Elliott

2. Date of Death  
Month Day Year

Jan. 31, 2011

3. Time of Death

13:33 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

6314 Carrington Court

4b. City, Town, or Location of Death

Capitol Heights

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

227-46-9940

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days Hours Min.

8. Date of Birth  
(Month, Day, Year)

Nov. 8, 1933

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6314 Carrington Court

10f. Zip Code

20743-1854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Nursing Special Police

16b. Kind of Business/Industry

DC Government

17. Father's Name (First, Middle, Last)

James E. Johnson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Hudson

19a. Informant's Name/Relationship (Type, Print)

Delores Trimiar - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8102 Fort Foote Rd., Fort Washington, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery or other place)

Fort Lincoln

Cedar Hill Cemetery

Date

2/7/2011

20c. Location - City or Town, State

Brentwood

Suitland, MD

21. Signature of Funeral Service Licensee

Judith K Johnson

22. Name and Address of Facility

J. K. Johnson Funeral Home P. A.

6503 Old Branch Ave., Temple Hills, MD 20748

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Approximate Interval Between Onset and Death

1 Hour

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

Hypertension

20 Years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Thrombocytosis

Hyperlipidemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Linda M. Green

29c. License number

D21428

29d. Date signed (Month, Day, Year)

Feb 3, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Green, MD 7582 Annapolis Road, Hyattsville, MD 20784

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Linda M. Green

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 23 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

## Certificate of Death

Reg. No. 2011 05627

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Jean Ilean Evans</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>1557 PM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |  | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>213-40-2600</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  | 8. Date of Birth<br>Month <b>8</b> Day <b>14</b> Year <b>1939</b>                                  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>333 Mill Street</b>  |  |   |  | 10f. Zip Code<br><b>21740</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>0</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>residence</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Luther Willman</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Florence Morganthall</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marlene Willman sister</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15641 National Pike Hagerstown, MD 21740</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Cem.</b>  |  | 20c. Date<br><b>2-11-2011</b>  |  | 20d. Location - City or Town, State<br><b>Hagerstown, MD</b>                                       |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald O. Paulsen RCFSP</b>   |  |   |  | 22. Name and Address of Facility<br><b>Donald Edwin Thompson Funeral Home, Inc<br/>P.O. BOX 310 Clear Spring, MD 21722</b>   |  |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>b. <b>Hypertension</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | Approximate Interval Between Onset and Death<br><b>240</b><br><b>304</b>   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>  |  |
|   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.              |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>   |  | 29c. License number<br><b>052323</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02-09-2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Muhammad Waseem, MD 1126 Opal Court Hagerstown, MD 21740</b>   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 2011</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

State  
Registrar

## Certificate of Death

Reg. No. 2011 05628

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEANNETTE

EADY

2. Date of Death

February 2, 2011

3. Time of Death

1655 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

5620 WHITFIELD CHAPEL ROAD T-2

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-40-9883

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1931

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

LANHAM

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5620 WHITFIELD CHAPEL ROAD T-2

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CATERIA WORKER

16b. Kind of Business Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

CHRISTOPHER EADY

18. Mother's Name (First, Middle, Maiden Surname)

JANIE DAVIS

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY EADY/DGT.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11568 DUNLORING DRIVE UPPER MARLBORO, MARYLAND 20772

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RIVERDALE CREMATORY

Date

2-4-2011

20c. Location - City or Town, State

RIVERDALE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME, INC.

7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H0053427

29d. Date signed (Month, Day, Year)

February 3, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Syparter 3001 Hospital Drive, Cheverly, Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05629

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |  |  |   |  |  |  |
|---|---|--|---|---|---|--|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Gerald Phillip Furlong</b>   |  |   |   |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>7</b> Year <b>2011</b>                        |   | 3. Time of Death<br><b>1:40 AM</b>                                   |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Washington Adventist Hospital</b>  |  |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>                                     |   | 4c. County of Death<br><b>Montgomery</b>                             |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>338-16-0945</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 8, 1922</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>Chicago, Illinois</b> |  |  |
|   | Usual Residence of Decedent   |  |   |   |   |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>Hyattsville</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |  |
|   | 10e. Street and Number<br><b>5313 Crittenden Street</b>   |  |   |   | 10f. Zip Code<br><b>20781</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>WWII</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Television Repairman</b>  |  |  | 16b. Kind of Business Industry<br><b>Hecht Company</b>                  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Furlong</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ellen Dougherty</b>  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Darlene G. Furlong / Daughter</b>  |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9105 Thamesmeade Road, Apartment G, Laurel, MD 20723</b> |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b> |   | Date<br><b>2/9/2011</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>      |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A. Hyattsville, MD 20781</b>             |   |  |  |   |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b>  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PNEUMONIA</b>   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
| Physician/<br>Medical<br>Examiner             | 23c. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>DEMENTIA</b>  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23d. Date of delivery<br>Month Day Year   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23f. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23g. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23h. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23i. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23j. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23k. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 23l. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
| To Be Completed by Physician/Medical Examiner | 24. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 25. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                                    |  | Approximate Interval Between Onset and Death |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 29b. Signature and title of certifier<br>   |  |   |   |   | 29c. License number<br><b>D-59284</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/7/2011</b>                  |  |  | Approximate Interval Between Onset and Death |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHARON SHAMMIM, MD. WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARK</b>   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |  |   |   |   | 32. Registrar's Signature<br>  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 33. Registrar's Signature<br>   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |
|   | 34. Registrar's Signature<br>   |  |   |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05630

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Anne Foster

2. Date of Death

Month 1/30/2011 Year

3. Time of Death

11:15aM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

1705 Governors Bridge Rd.

4b. City, Town, or Location of Death

Davidsonville

4c. County of Death

Anne Arundel

5. Social Security Number

219-30-5610

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4/7/1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1705 Governors Bridge RD.

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give

Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

College (1-4 or 5+)

17. Father's Name (First, Middle, Last)

Frank Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Ireland

19a. Informant's Name/Relationship (Type, Print)

Elmer Foster Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 Governors Bridge Rd. Davidsonville, MD 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakemont Memorial

Date

2/3/2011

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

D. J. Chen

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Breast carcinoma

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be determined  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. Goldstein

29c. License number

D26743

29d. Date signed (Month, Day, Year)

1/31/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.D. Goldstein, M.D. 116 Defense Hwy Annap. md 21401

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

D. J. Chen

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05631

1- For  
State  
Registrar

|  |  |  |   |   |  |  |  |   |   |  |
|--|--|--|---|---|--|--|--|---|---|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES OLIVER GROVES</b>   |  |   |   | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>17</b> Year <b>2011</b>   |  |  |   | 3. Time of Death<br><b>4:29 p.m.</b>  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Union Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |  |  |   | 4c. County of Death<br><b>Cecil</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-16-6203</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>January 5 1922</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Cecil</b>   |   | 10c. City, Town or Location<br><b>Cecilton</b>   |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>172 Center St. Apt. 3-A</b>   |  |   |   | 10f. Zip Code<br><b>21913</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>-1945</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farm Manager</b>   |  |  | 16b. Kind of Business Industry<br><b>Beef Farms</b>                     |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Arthur Groves</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mabel Cleaver</b>  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy Wallace (daughter)</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>860 Court House Point Rd. Chesapeake City, MD 21915</b>                                      |  |  |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Zion Cemetery</b>  |   | Date<br><b>2/24/11</b>   |  | 20c. Location - City or Town, State<br><b>Cecilton, MD.</b>  |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | M00510  |   | 22. Name and Address of Facility<br><b>Galena Funeral Home of Stephen L. Schaech<br/>118 West Cross St. Galena, MD. 21635</b>  |  |  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Prostate Cancer</b><br>Approximate Interval Between Onset and Death |  |   |   |  |  |  |   |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |   |  |  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>g <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   |  |  | 23d. Date of delivery<br>Month Day Year  |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |
|  |  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |  |   |   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D-0054086</b> |  | 29d. Date signed (Month, Day, Year)<br><b>02-17-2011</b> |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMIL KHATRI, MD. 111 West High St. Elkton, MD. 21921</b>   |  |  |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  | 32. Registrar's Signature<br>  |   |   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

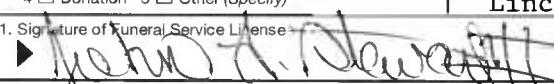


1- For State Registrar **Amend Items 25, 27, 28a-f per me, 8916, 06/20/2011dhb** State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death Reg. No. **2011 05632**

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Bernardo L. Gomez</b>  |   | 2. Date of Death<br>Month <b>January</b> Day <b>31</b> , Year <b>2011</b>   |  | 3. Time of Death<br><b>10:08 A M</b>   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Larkin Chase Nursing Center</b>  |   | 4b. City, Town, or Location of Death<br><b>Bowie</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-24-0154</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 11, 1925</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>DC</b>   |   | 10a. State<br><b>DC</b>   |  |  |
| To Be Completed by Funeral Director   | 10b. County<br><b>Washington</b>  |   | 10c. City, Town or Location<br><b>Washington</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>4638 A Street SE</b>   |   | 10f. Zip Code<br><b>20019</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>         |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Shipping Manager</b>  |   | 16b. Kind of Business Industry<br><b>Brooks Brothers</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Lucio P. Gomez</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Kinley</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris L. Anderson - Sister</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4815 Jefferson Street Lanham, Maryland 20706</b>  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Memorial</b>   |  | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility <b>Stewart Funeral Home, Inc.</b><br><b>4001 Benning Road NE Washington, DC 20019</b>                                |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac Arrhythmia</b><br>Due to (or as a consequence of):<br>b. <b>Atrial Fibrillation</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death minutes<br><b>years</b><br><b>years</b> |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Traumatic Brain</b><br><b>Dysphagia</b><br><b>Chronic Obstructive Pulmonary Disease</b>  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day, Year)<br><b>11/20/2010</b>   |   | 28b. Time of injury<br><b>6:30 p. M</b>  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred<br><b>Subject was a passenger in a motor vehicle accident</b>   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Largo Road near Castleton Drive, Largo MD</b>  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D0051437</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 8, 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Okeowo Darcy Ibitoye 12200 Annapolis Rd. #232 Glenn Dale, Md. 20769</b>  |   |   |   |  |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |   | 32. Registrar's Signature<br>                                      |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05633

1- For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josiah J. Gilpin

2. Date of Death

Month February Day 2 Year 2011

3. Time of Death

9:35P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Brooke Grove Nursing Home

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

5. Social Security Number

218-24-0930

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) March 4 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4201 Briars Road

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

1952-1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Forester

16b. Kind of Business Industry

Forestry

17. Father's Name (First, Middle, Last)

William Gilpin

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Jones

19a. Informant's Name/Relationship (Type, Print)

Joanne G. Gilpin / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4201 Briars Road, Olney, Maryland 20832

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crem.

Date

2/4/2011

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Roy W. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home  
P. O. Box 5038, Laytonsville, Md. 20882

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

RENAL FAILURE

Approximate Interval Between Onset and Death  
DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

HYPERKALEMIA

DAYS

c. Due to (or as a consequence of):

DEHYDRATION

DAYS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER, CONGESTIVE  
HEART FAILURE, ATRIAL FIBRILLATION  
W/OUT, CHRONIC OBSTRUCTIVE LUNG DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ ODAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anuradha Arun, M.D.

29c. License number

D0057630

29d. Date signed (Month, Day, Year)

02-03-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anuradha Arun, M.D. 10301 Georgia Ave., Suite 209, Silver Spring, Md. 20902

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Anuradha Arun

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05634

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Wayne Gabrielsen

2. Date of Death  
Month Day Year

February 2 2011

3. Time of Death

1045 AM

4a. Facility Name (if not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

216-42-1975

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

June 18, 1944

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Toddville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1860 St. Thomas Church Road

10f. Zip Code

21672

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ NoIf Yes, Give  
Year or Dates: 196513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

lineman

16b. Kind of Business Industry

electric company

17. Father's Name (First, Middle, Last)

Jerome Gabrielsen

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Kling

19a. Informant's Name/Relationship (Type, Print)

Rachel Gabrielsen

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1860 St. Thomas Church Rd., Toddville, MD 21672

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cem.

Date

2/4/11

20c. Location - City or Town, State

Hurlock, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0053815

29d. Date signed (Month, Day, Year)

2/2/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KORAH PULMONO 912 D Market Street Denton MD 21629

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0036 hdb  
Kenneth Gabrielsen  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05635

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|  |  |  |  |                                     |
|--|--|--|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>CHRISTOPHER MICHAEL HOEFERT</b> |  | 2. Date of Death<br>Month Day Year<br><b>February 15, 2011</b> |  | 3. Time of Death<br><b>1615 hrs</b> |
|--|--|--|--|-------------------------------------|

Funeral  
Director

|   |  |   |  |   |
|---|--|---|--|---|
| 4a. Facility Name (if not institution, give street and number)<br><b>Prince George's Hospital</b> |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b> |  | 4c. County of Death<br><b>Prince George's</b> |
|---|--|---|--|---|

|   |  |  |   |  |
|---|--|--|---|--|
| 5. Social Security Number<br><b>107-70-1722</b> | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>24</b> Yrs. | 8. Date of Birth (MM/DD/YYYY)<br><b>3-21-1986</b> | 9. Birthplace (State or Foreign Country) <b>N.Y.</b> |
|---|--|--|---|--|

|                             |                               |  |  |  |
|-----------------------------|-------------------------------|--|--|--|
| Usual Residence of Decedent |                               | 10c. City, Town or Location<br><b>LA PLATA</b> |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10a. State<br><b>MD.</b>    | 10b. County<br><b>CHARLES</b> |  |  |  |

|  |  |                               |  |
|--|--|-------------------------------|--|
| 10e. Street and Number<br><b>6420D WARREN C. ELLER DRIVE</b> |  | 10f. Zip Code<br><b>20646</b> | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
|--|--|-------------------------------|--|

|  |  |  |  |   |
|--|--|--|--|---|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |
|--|--|--|--|---|

|   |  |   |  |
|---|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HIGH SCHOOL TEACHER</b> | 16b. Kind of Business/Industry<br><b>NORTH POINT HIGH SCHOOL</b> |
|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>HERMAN CHARLES HOEGERT</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DEBRA MARIE LOMBARDI</b> |  |
|--|--|--|--|

|   |  |   |  |
|---|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HERMAN C. HOEFERT-FATHER</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5785 JOY ROAD CONESUS, N.Y. 14435</b> |  |
|---|--|---|--|

|  |  |   |                        |  |
|--|--|---|------------------------|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ATLANTIC CREMATORY</b> | Date<br><b>2-18-11</b> | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b> |
|--|--|---|------------------------|--|

|  |  |   |  |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee<br><i>Michael L. ...</i> <b>400479</b> |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.<br/>LA PLATA, MARYLAND 20646</b> |  |
|--|--|---|--|

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

|   |  |  |  |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Gunshot Wounds</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  | Approximate Interval Between Onset and Death |  |
|---|--|--|--|

|  |  |   |  |   |
|--|--|---|--|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |
|--|--|---|--|---|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br> |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |  |  |
|---|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)<br><b>Feb 15, 2011</b>  | 28b. Time of Injury<br><b>1515 hrs</b> | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred<br><b>Subject shot</b> |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Local Street</b> |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Billingsley Road / Middletown Road, Waldolf, MD</b> |  |

|   |  |
|---|--|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|---|--|

|   |  |   |
|---|--|---|
| 29b. Signature and title of certifier<br><i>Carol Allan</i> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>February 16, 2011</b> |
|---|--|---|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |  |
|--|--|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b> | 32. Registrar's Signature<br><i>Anna B. ...</i> |
|---|---|

State  
Registrar

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05636

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Mae Harding

2. Date of Death

February 6 2011

3. Time of Death

1240 PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital at Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

218-24-5375

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 21, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

129 Bloomingdale Avenue

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business Industry

Sewing

17. Father's Name (First, Middle, Last)

Nelson Covey

18. Mother's Name (First, Middle, Maiden Surname)

Sarah J. Williamson

19a. Informant's Name/Relationship (Type, Print)

Michael Harding/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4744 Preston Road, Federalsburg, MD 21632

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hill Crest Cem.

Date

02/19/11

20c. Location - City or Town, State

Federalsburg, MD

21. Signature of Funeral Service Licensee

Michael CFSP

22. Name and Address of Facility

Frampton Funeral Home, P.A.  
216 N. Main St. Federalsburg, MD 21632

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis M. Deshields MD

29c. License number

00053110

29d. Date signed (Month, Day, Year)

February 6 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis M. Deshields, 219 S. Washington St., Easton, MD 21601

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 3 per med cert 6913 3/17/11 dk  
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05637

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter Richard Holloway Sr.

2. Date of Death

Month Day Year  
February 5, 2011

3. Time of Death

1300 P M

4a. Facility Name (if not institution, give street and number)

419 Parkwood

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

213-22-9735

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

11/10/1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

419 Parkwood

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Mortician

16b. Kind of Business Industry

Funeral

17. Father's Name (First, Middle, Last)

Walter R. Holloway

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Jones

19a. Informant's Name/Relationship (Type, Print)

John M. Holloway/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26308 Kensington Lane, Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Wicomico Memorial

Park

Date

2/9/2011

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

W R Holloway CFSP

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Prostate Cancer

Approximate Interval Between Onset and Death

Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. P. P.

29c. License number

D36576 MD

29d. Date signed (Month, Day, Year)

2/2/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONALD P. TANYITZ MD 1665 WOODBROOK DR SALISBURY MD 21804  
560 RIVERSIDE DR SALISBURY MD 21804

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Laura A. Spade

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2011 05638

1- For State Registrar

Reg. No.

Physician/  
Medical Examiner

|   |  |   |  |                                     |
|---|--|---|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Janis Elizabeth Huey-Dulis Janis Dulis</b> |  | 2. Date of Death<br>Month Day Year<br><b>February 5, 2011</b> |  | 3. Time of Death<br><b>1613 hrs</b> |
|---|--|---|--|-------------------------------------|

|  |  |  |
|--|--|--|
| 4a. Facility Name (if not institution, give street and number)<br><b>Peninsula Regional Medical Center</b> | 4b. City, Town, or Location of Death<br><b>Salisbury</b> | 4c. County of Death<br><b>Wicomico</b> |
|--|--|--|

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| 5. Social Security Number<br><b>177-60-7314</b> | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>32</b> Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>Jan. 11, 1979</b> | 9. Birthplace (State or Foreign Country)<br><b>PA</b> |
|---|--|--|---|---|---|

|                             |                                |  |  |
|-----------------------------|--------------------------------|--|--|
| Usual Residence of Decedent |                                | 10c. City, Town or Location<br><b>Delmar</b> | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10a. State<br><b>MD</b>     | 10b. County<br><b>Wicomico</b> |  |  |

|  |                               |  |
|--|-------------------------------|--|
| 10e. Street and Number<br><b>104 East State Street</b> | 10f. Zip Code<br><b>21875</b> | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
|--|-------------------------------|--|

|  |  |  |   |
|--|--|--|---|
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |
|--|--|--|---|

|  |  |   |
|--|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waitress</b> | 16b. Kind of Business/Industry<br><b>Food Service</b> |
|--|--|---|

|   |   |
|---|---|
| 17. Father's Name (First, Middle, Last)<br><b>Rennard W. Huey</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Georgia M. Ungureit</b> |
|---|---|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Georgia M. Salazar (Mother)</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>384 Carey Avenue Wilkes-Barre, PA 18702</b> |
|--|---|

|  |  |                                |  |
|--|--|--------------------------------|--|
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crematory of Delmarva</b> | 20c. Date<br><b>02-11-2011</b> | 20d. Location - City or Town, State<br><b>Delmar, Delaware</b> |
|--|--|--------------------------------|--|

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br><i>A. G. [Signature]</i> | 22. Name and Address of Facility<br><b>Short Funeral Home<br/>13 East Grove Street Delmar, Delaware 19940</b> |
|---|---|

|   |  |  |
|---|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a: <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b:<br>Due to (or as a consequence of):<br>c:<br>Due to (or as a consequence of):<br>d:<br>[X] UNPENDED [X] AMENDED <b>1, 23a, 27, g915 5-13-11 sm</b> |  | Approximate Interval Between Onset and Death |
|---|--|--|

|   |   |   |
|---|---|---|
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|---|---|---|

|  |  |  |
|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br> |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |

|   |  |
|---|--|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other: |
|---|--|

|   |  |  |   |                                   |
|---|--|--|---|-----------------------------------|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                                   |

|  |
|--|
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|--|

|  |  |  |
|--|--|--|
| 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i> | 29c. License number<br><b>O.C.M.E.</b> | 29d. Date signed (Month, Day, Year)<br><b>February 6, 2011</b> |
|--|--|--|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |
|---|

|   |   |
|---|---|
| 31. Date filed (Month, Day, Year)<br><b>FEB 15 2011</b> | 32. Registrar's Signature<br><i>[Signature]</i> |
|---|---|

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician Medical Examiner  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anna Louise Harvey

2. Date of Death

Month 2 Day 1 Year 2011

3. Time of Death

6:10 P M

4a. Facility Name (if not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

5. Social Security Number

214-07-7613

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3-11-1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

108 Maryland Avenue

10f. Zip Code

21643

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Frank

18. Mother's Name (First, Middle, Maiden Surname)

Amy Evans

19a. Informant's Name/Relationship (Type, Print)

Clarence Ben Harvey - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 Academy Avenue, Federalsburg, Maryland 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cem. - ES

Date

2-7-2011

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

Melissa Henry Blake

22. Name and Address of Facility

Bounds Funeral Home  
705 E. Main Street, Salisbury, Maryland 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sides MD

29c. License number

D31376

29d. Date signed (Month, Day, Year)

2-2-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides 920 Market St Denton MD

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Anna P. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05640

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marvin

C.

Hawkins

2. Date of Death

Month Day Year  
2-5-2011

3. Time of Death

3:21p M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Fort Washington Medical

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George

5. Social Security Number

215-46-0474

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

8. Date of Birth (Month, Day, Year)

4-15-1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6801 Floral Park Rd

10f. Zip Code

20613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. 1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Environmental Protection Agency Manager

16b. Kind of Business Industry

Federal Government

17. Father's Name (First, Middle, Last)

Daniel M. Hawkins Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marion P Walls

19a. Informant's Name/Relationship (Type, Print)

Carroll Hawkins/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9590 Crain Hwy Apt 412, Upper Marlboro MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Bethel

Date

2-12-11

20c. Location - City or Town, State

Brandywine, MD

21. Signature of Funeral Service Licensee

Theresa Neal

22. Name and Address of Facility

Adams Funeral Home Pa, Aquasco, MD 20608

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Respiratory failure

Approximate Interval Between Onset and Death

Sudden

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Total Hip replacement (left) January 31

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

NIA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NIA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sayer

29c. License number

D0022051

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR AZER M.D., 11701 Livingston Rd., Fort Washington, Md 20744

31. Date filed (Month, Day, Year)

2/7/11 FEB 10 2011

32. Registrar's Signature

Sara A. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05641

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hilda Jane HOSE

2. Date of Death

Month Day Year  
February 6, 2011

3. Time of Death

10:28 p.<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

26 South Locust Street

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

216-14-6090

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

26 South Locust Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

17. Father's Name (First, Middle, Last)

Alexander Bowers

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Belle Troxell

19a. Informant's Name/Relationship (Type, Print)

Diane Schiano-DiCola -daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26 S. Locust St., Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rose Hill Cemetery

Date

2/10/2011

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Munnich

22. Name and Address of Facility

MINNICH FUNERAL HOME  
415 E. Wilson Blvd., Hagerstown, Md. 2174023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiorespiratory Failure

Due to (or as a consequence of):

b. Hypertensive Heart Disease

Due to (or as a consequence of):

c. Hyperlipidemia

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Weeks

Years

Years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident  
Recurrent Urinary Tract Infection

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

TANVIR A. PASHA, MD

29c. License number

D35497

29d. Date signed (Month, Day, Year)

2-8-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TANVIR A. PASHA, MD 1122 OPAL CT. Hagerstown MD 21740

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Anna S. Jones

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05612

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gerald Joseph Hetz

2. Date of Death

February 3, 2011

3. Time of Death

11:45 A M

4a. Facility Name (If not institution, give street and number)

Frostburg Village Nursing Home

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

5. Social Security Number

215-44-9018

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 13, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14108 Cederwood Dr., SW

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Tire Manufacturer

17. Father's Name (First, Middle, Last)

Clarence Edward Hetz

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Christine Garlitz

19a. Informant's Name/Relationship (Type, Print)

Lea Grace Chevalier/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12127 Old Legislative Rd., SW, Frostburg, MD 21532

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Country Side Crematory Feb. 4, 2011 Davidsville, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Newman Funeral Homes, P.A.  
P.O. Box 275, Grantsville, MD 21536

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage liver cirrhosis

Approximate Interval Between Onset and Death

6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute pneumonia left

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

071244

29d. Date signed (Month, Day, Year)

2/3/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jesus H. Tan, 4 Broadway, Frostburg, MD 21532

31. Date filed (Month, Day, Year)

FEB - 9 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3 VA

State  
Registrar

2-392-81-92

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05613

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Terri

Hall

2. Date of Death  
Month Day Year  
February 1 20113. Time of Death  
6:31 AM

4a. Facility Name (If not institution, give street and number)

Mc Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

217-68-9216

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Feb 11 1957

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15647 Mews Ct.

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

4yrs

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Medical Assistant

16b. Kind of Business/Industry

Maryland  
Orthopedics

17. Father's Name (First, Middle, Last)

Percy L. Alston

18. Mother's Name (First, Middle, Maiden Surname)

Audrey P. Mack

19a. Informant's Name/Relationship (Type, Print)

Thomas R. Hall (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15647 Mews Ct. Laurel, Md. 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

2-7-11

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Ferry H. Allen MO0483

22. Name and Address of Facility

Wm. Reese & Sons Mortuary, P.A.  
821 West St. Annapolis, Md. 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sul M

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 1, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Satish Misra, MD John Hopkins 600 North Street, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Renee S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05644

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Kathryn Elizabeth Hill

2. Date of Death

January 29, 2011

3. Time of Death

2:20 A M

4a. Facility Name (if not institution, give street and number)

Crofton Care and Rehabilitation

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

186-16-2126

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07/27/1922

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1515 Crofton Parkway

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Personnel

16b. Kind of Business Industry

P.G. Co. Community Col

17. Father's Name (First, Middle, Last)

William Henry Hannam

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Elizabeth O'Connell

19a. Informant's Name/Relationship (Type, Print)

Ruffner L. Hill Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1515 Crofton Parkway Crofton, MD 21114

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Atlantic Crematory

Date

01/31/2011

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Batt J

22. Name and Address of Facility

Hardesty Funeral Home P.A. 851 Annapolis Road  
Gambrells, MD 2105423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Failure to thrive, Adult

Approximate  
Interval Between  
Onset and Death

2 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Dementia of Lewes Bodies

5 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease  
Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Berez MD

29c. License number

D0029571

29d. Date signed (Month, Day, Year)

01/31/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul B. Berez, MD 2225 E Defense Hwy, Crofton, MD 21114

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

Anna B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
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once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 27,24a per dr., g912.02/24/2011dhp

Certificate of Death

Reg. No.

2011 05646

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma C.M. Johnson</b>   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>8</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>7:50 PM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>St. Catherine's Nursing Home</b>  |  | 4b. City, Town, or Location of Death<br><b>Emmitsburg</b>   |  | 4c. County of Death<br><b>Frederick</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>198-05-4154</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 1, 1914</b> | 9. Birthplace (State or Foreign Country)<br><b>Philadelphia, PA</b>  |
|  | Usual Residence of Decedent  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>Frederick</b>  | 10c. City, Town or Location<br><b>Emmitsburg</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>331 S. Seton Ave.</b>   |  | 10f. Zip Code<br><b>21727</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Operator</b>   |  | 16b. Kind of Business/Industry<br><b>Meat Packing</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Babl</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara Kastner</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sr. Thelma B. Steiger</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>631 Tract Rd., Fairfield, PA 17320</b>        |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Feb. 10, 2011 Smithsburg, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Jeffrey Lee Davis</b>  |  | 22. Name and Address of Facility<br><b>J.L. Davis Funeral Home<br/>12525 Bradbury Ave., Smithsburg, MD 21783</b>                                  |  |  |
|  | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe Aortic Stenosis</b>   |  |   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)   |  |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  |  |   |  |  |
| 28b. Time of Injury<br>M   |  |  |   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 28d. Describe how injury occurred  |  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Jeffrey Lee Davis</b>  |  |  |   |  |  |
| 29c. License number<br><b>Heck4403</b>   |  |  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>02-09-2011</b>   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bonita W. Kneuper - Fortier DO</b>  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |  |  |   |  |  |
| 32. Registrar's Signature<br><b>Deanna A. Spauld</b>   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05647

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Jones

2. Date of Death

FEBRUARY 4 2011

3. Time of Death

1847 M

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center Cheverly

4b. City, Town, or Location of Death

4c. County of Death

P.G.

Funeral  
Director

5. Social Security Number

578-56-8929

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

April 30, 40

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3710 Grant Place NE

10f. Zip Code

20019

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Shipping/Receiving Clerk

16b. Kind of Business/Industry

Federal Gov.

17. Father's Name (First, Middle, Last)

Fred Jones

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Mae Quarles

19a. Informant's Name/Relationship (Type, Print)

Gerald Wingfield- son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6408 Rosalie Lane Riverdale, Md. 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet

Date

Feb 12, 11 Washington, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

John E. Robinson

22. Name and Address of Facility

Wash., D.C. 20001  
Robinson Funeral Home 1313 6th St. NW

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRAVENTRICULAR CEREBRAL HEMORRHAGE

Approximate Interval Between Onset and Death

7 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PULMONARY EMBOLUS

7 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TRACHEAL BLEEDING, trace, in secretions

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Revathy Murthy

29c. License number

D16273

29d. Date signed (Month/Day/Year)

2/4/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR REVATHY MURTHY 3001 HOSPITAL DRIVE CHEVERLY, MD 20785

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05648

1- For  
State  
Registrar

|  |  |   |   |   |  |  |  |  |
|--|--|---|---|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Sarah Elizabeth Jones</b>   |   |   | 2. Date of Death<br>Month: <b>February</b> Day: <b>08</b> Year: <b>2011</b>   |  | 3. Time of Death<br><b>2:32p<sup>M</sup></b>   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-38-1046</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 23, 1941</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Washington</b>   |  | 10c. City, Town or Location<br><b>Boonsboro</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>13 Della Lane</b>  |   | 10f. Zip Code<br><b>21713</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cytotechnologist</b>  |   | 16b. Kind of Business Industry<br><b>Medical</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Milton Gloss</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Goldie Louise Long</b>  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eldon A. Jones / Husband</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13 Della Lane Boonsboro, Maryland 21713</b> |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Boonsboro Cemetery</b>   |   | Date<br><b>02-12-2011</b>  |  | 20c. Location - City or Town, State<br><b>Boonsboro, Maryland</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Bast-Stauffer Funeral Home, PA<br/>7606 Old National Pike Boonsboro, MD 21713</b>  |   |  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Liver Failure</b><br>a. Due to (or as a consequence of):<br><b>Hepatic Encephalopathy</b><br>b. Due to (or as a consequence of):<br><b>Resp Failure</b><br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |   |  |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br><b>D50362</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 9, 2011</b>                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vincent Cantone, MD 13424 Pennsylvania Ave. Hagerstown, MD 21742</b>  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05649

1- For  
State  
Registrar

|   |  |  |   |   |   |  |   |   |  |  |
|---|--|--|---|---|---|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ruth R. Jackson</b>   |  |   | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>2011</b> |   |  | 3. Time of Death<br><b>2:05 A M</b>                         |   |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Goodwill Mennonite Home</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Grantsville</b>              |   |  | 4c. County of Death<br><b>Garrett</b>                       |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>259-60-0081</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 11, 1920</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent  |  |   |   |   |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Garrett</b>   |   | 10c. City, Town or Location<br><b>Oakland</b>   |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>233 N. Second St.</b>   |  |   |   | 10f. Zip Code<br><b>21550</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                 |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Co-Owner</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Co-Owner</b>  |  |   | 16b. Kind of Business Industry<br><b>Retail</b>                         |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ernest Roy Ridder</b>  |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sara Dorothy Baker</b> |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ethel Cosner/Sister</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>134 Church Lane, Oakland, MD 21550</b>  |  |   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Country Side Crematory Feb. 10, 2011 Davidsville, PA</b>   |  | 20c. Location - City or Town, State                         |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>D. Lynn Dorman</b>   |  |   |   | 22. Name and Address of Facility <b>Newman Funeral Homes, P.A.</b><br><b>P.O. Box 386, Oakland, MD 21550</b>  |  |   |   |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Respiratory failure</b><br>Due to (or as a consequence of):<br><b>pneumonia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |   |  |   |   |  |  |
|   | Approximate Interval Between Onset and Death   |  |   |   |   |  |   |   |  |  |
| Physician/<br>Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |   |   |  |   |   |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |   |   |  |   |   |  |  |
|   | 23d. Date of delivery<br>Month Day Year  |  |   |   |   |  |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Uterine cancer</b><br><b>Alzheimer dementia</b>   |  |   |   |   |  |   |   |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |   |   |  |   |   |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |  |   |   |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |  |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |  |   |   |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |   |   |  |   |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |   |   |  |   |   |  |  |
| 28a. Date of injury (Month, Day, Year)  |  |  |   |   |   |  |   |   |  |  |
| 28b. Time of injury<br>M  |  |  |   |   |   |  |   |   |  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |   |   |  |   |   |  |  |
| 28d. Describe how injury occurred   |  |  |   |   |   |  |   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |   |   |  |   |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>U. A. Ameen MD</b>  |  |  |   |   |   |  |   |   |  |  |
| 29c. License number<br><b>D0066150</b>  |  |  |   |   |   |  |   |   |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/7/2011</b>  |  |  |   |   |   |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Muhammad Naeem 625 Kent Ave Suit 204 Cumberland MD</b>   |  |  |   |   |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB - 9 2011</b>  |  |  |   |   |   |  |   |   |  |  |
| 32. Registrar's Signature<br><b>John A. Parker</b>  |  |  |   |   |   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

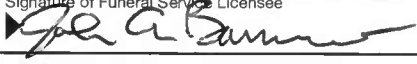
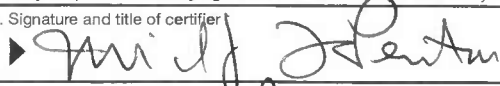
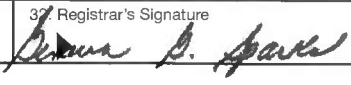
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05650

1- For  
State  
Registrar

|  |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MYERS W JAY</b>   |  |  | 2. Date of Death<br>Month <b>02</b> Day <b>01</b> Year <b>2011</b>   |  |  | 3. Time of Death<br><b>2230 M</b>  |  |   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Annapolitan Assisted Living</b>   |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-03-6802</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 17, 1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b> |  |  |
|  | 10a. State<br><b>MD</b>  |  |  | 10b. County<br><b>Anne Arundel</b>   |  |  | 10c. City, Town or Location<br><b>Annapolis</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>1001 Fairwinds Drive</b>  |  |  | 10f. Zip Code<br><b>21409</b>  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b><br>If Yes, Give Year or Dates. |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Captain</b>                                    |  |  | 16b. Kind of Business Industry<br><b>Merchant Marine</b>   |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Willis P. Jay</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Caroline Azile Bond</b>  |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen L. Pumphrey / Daughter</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 Fairwinds Drive Annapolis, MD 21409</b>               |  |  |  |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen Cemetery</b>  |  |  | Date<br><b>February 14, 2011</b>   |  | 20c. Location - City or Town, State<br><b>Jacksonville, FL</b>    |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Ritchie Hwy, Severna Park, MD 21146</b>                     |  |  |  |  |   |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CA PROSTATE</b> |  |  |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Y 20/25</b> |
|  | 23b. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>AAA GI BLEED</b>   |  |  |  |  |  |  |  |   |  |  |
|  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown        |  |  |  |  |  |  |  |   |  | 23d. Date of delivery<br>Month Day Year                        |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>AAA GI BLEED</b>  |  |  |  |  |  |  |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>ANNAPOLITAN ALF</b> |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  |  |  |  |  |  |   | 28a. Date of injury (Month, Day, Year)   |  |
| 28b. Time of injury<br>M   |  |  |  |  |  |  |  |  |   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred<br><b>ALF</b>  |  |  |  |  |  |  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |  |  |  |  |  |  |  |  |   | 29c. License number<br><b>D 21438</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>February 02 2011</b>   |  |  |  |  |  |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL J. LAPENTA 445 DEFENSE HWY ANNAPOLIS MD 21401</b>   |  |  |  |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>  |  |  |  |  |  |  |  |  |   | 32. Registrar's Signature<br>   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05651

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary Louise Johnson</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>4</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>5:23 PM</b>   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |   | 4c. County of Death<br><b>Frederick</b>  |   |
| 5. Social Security Number<br><b>218-16-2035</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth<br>Month <b>July</b> Day <b>8</b> Year <b>1924</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent  |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Damascus</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>26300 Howard Chapel Drive</b>   |  | 10f. Zip Code<br><b>20872</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   |
| 16b. Kind of Business Industry<br><b>Own home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Charles Edward Stanley</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Daphane Watkins</b>  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James V. Johnson, Jr., - Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20872</b><br><b>26300 Howard Chapel Drive, Damascus, Maryland</b>  |   |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. View Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Damascus, Maryland</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Robert L. Williams</b>   |  | 22. Name and Address of Facility<br><b>Molesworth-Williams P.A., Funeral Home</b><br><b>26401 Ridge Road, Damascus, Maryland 20872</b>  |   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>CHF</b><br>Due to (or as a consequence of):<br>c. <b>copd</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  | Approximate Interval Between Onset and Death                |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)<br><b>M</b>  |   | 28b. Time of injury<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 28c. Describe how injury occurred  |  | 28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.      |  |   |   |  |   |
| 29b. Signature and title of certifier<br><b>T. Senehye M.D.</b>  |  | 29c. License number<br><b>MD069963</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/6/2011</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sandhya Thakallapali 400 W 7th St Frederick, MD 21701</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05652

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Angela Lorraine Johnson-Barry

2. Date of Death

Month Day Year  
Feb. 2, 2011

3. Time of Death

15:10 P M

4a. Facility Name (if not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-02-8478

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 24, 1965

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2401 Vidalia Court

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Registered Nurse

16b. Kind of Business Industry

Healthcare

17. Father's Name (First, Middle, Last)

Shelly Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Cobbs

19a. Informant's Name/Relationship (Type, Print)

Kevin Barry - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 Vidalia Court, Waldorf, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resurrection Cemetery 2/11/2011

Date

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

J. K. Johnson Funeral Home PA

22. Name and Address of Facility

6503 Old Branch Ave., Temple Hills, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEPSIS

a. Due to (or as a consequence of):

PNEUMONIA

b. Due to (or as a consequence of):

BREAST CANCER

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

MD

29c. License number

D0064986

29d. Date signed (Month, Day, Year)

2/3/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chika Onwuka 7503 Surratts Rd. Clinton, Md 20735

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05653

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ada Lorraine Kennedy</b>   |  |   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>1126<sup>AM</sup></b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>   |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |   | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>214-30-1641</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1932</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| Usual Residence of Decedent   |  |   |  |   |  |  |   |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>633 W. Franklin St.</b>  |  |   |  | 10f. Zip Code<br><b>21740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  | 16b. Kind of Business Industry<br><b>Home</b>                           |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John L. Mills</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Domer</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael J. Hammond (Son)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2005 Maplewood Dr. Hagerstown, Md. 21740</b>  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | Date<br><b>Feb. 17, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Smithsburg, Md.</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>J. L. Davis</b> MO1414  |  |   |  | 22. Name and Address of Facility<br><b>J.L. Davis Funeral Home</b> 12525 Bradbury Ave. Smithsburg, Md. 21783  |  |  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Acute mesenteric ischemia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Acute Kidney Disease</b><br>Due to (or as a consequence of):    |  |   |  |   |  |  |   |  | Approximate Interval Between Onset and Death |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)                                       |  |   |  |  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>J. L. Davis</b>   |  |   |  | 29c. License number<br><b>0060396</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>21 15 11</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FARID MURSHED</b> 126 Opal Ct Hagerstown, MD 21742   |  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

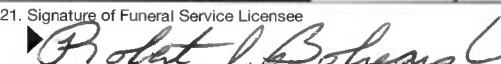
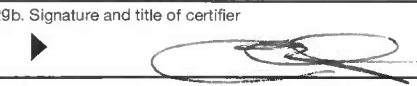
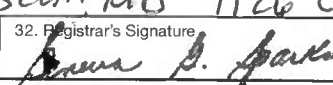
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 10b, c, e, f, per 11, g 914, 04/15/2011dnhb  
 State of Maryland / Department of Health and Mental Hygiene  
 1- For State Registrar Amend Item 24a per verb., g 912, 02/24/2011dnhb  
 Certificate of Death  
 Reg. No. 2011 05654

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor Macrae Keenan</b>  |   | 2. Date of Death<br>Month Day Year<br><b>February 4, 2011</b>   |  | 3. Time of Death<br><b>10:50 M</b>   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>   |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>300-12-1822</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>95 Yrs.</b>  | 8. Date of Birth (Month Day Year)<br><b>02-20-1916</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>huntington, wv</b>   |   | 10. Usual Residence of Decedent   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>WV</b>   | 10b. County<br><b>Kanawha</b><br><del>Berkeley</del>  | 10c. City, Town or Location<br><b>St. Albans</b><br><del>Bunker Hill</del>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>7 Dawn Court 740 Holley Street</b>   |   | 10f. Zip Code<br><b>25413-25177</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Seconday (0-12) College (1-4 or 5+)<br><b>5</b>                         |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Librarian</b>   |   | 16b. Kind of Business Industry<br><b>Government</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John A. MacRae</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie M. Herring</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alexander Keenan (Son)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Dawn Court, Bunker Hill, WV 25413</b>           |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WVU Memorial Vault</b>   |  | 20c. Location - City or Town, State<br><b>02-07-2011 Morgantown, wv</b>  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>WVU Human Gift Registry<br/>PO Box 9131, Morgantown, WV 26506</b>  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Dementia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>40</b><br><b>57</b> |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)<br><b>M</b>  |   | 28b. Time of injury<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>052323</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>02-04-2011</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Muhammad Waseem MD 1126 Opal Court Hagerstown, MD 21740</b>  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>  |   | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05655

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Marian Elizabeth Knott</b>  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>February 7, 2011</b>                        |  | 3. Time of Death<br><b>1743 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>DORCHESTER GENERAL HOSPITAL</b>   |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>CAMBRIDGE</b>                             |  | 4c. County of Death<br><b>DORCHESTER</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-16-8476</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>February 16, 1924</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Dorchester</b>  |  | 10c. City, Town or Location<br><b>Secretary</b>  |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 10e. Street and Number<br><b>129 Main Street</b>   |  |   |  | 10f. Zip Code<br><b>21664</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>11 H.S. Grad.</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Family</b>  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Marion Emmitt Potts</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Elizabeth Turner</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marian K. Mullinix/daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>129 Main Street, Secretary, Maryland 21664</b>   |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Denton Cemetery</b>  |  | Date<br><b>Feb. 11, 2011</b>   |  | 20c. Location - City or Town, State<br><b>Denton, Maryland</b>                       |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Russell Moore</i>  |  | 22. Name and Address of Facility<br><b>Moore Funeral Home, P.A.<br/>12 South Second Street, Denton, Maryland 21629</b>  |  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Acute Renal Failure</b>   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Aspirations pneumonia</b>   |  |   |  |  |  |  |  |   |  |
|   | Due to (or as a consequence of):   |  |   |  |  |  |  |  |   |  |
|   | Due to (or as a consequence of):   |  |   |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
| State<br>Registrar                            | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ahmed Labib MD</b>  |  | 29c. License number<br><b>D65528</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02/07/2011</b>                             |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ahmed Labib MD, 300 Byrn St., Cambridge MD 21613</b>  |  |   |  |  |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |   |  |
|   |  |  |   |  |  |  |  |  |   |  |

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05656

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD KISLY

2. Date of Death

FEBRUARY

Day

Year

3. Time of Death

05:54 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

144-38-2363

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

8. Date of Birth

09/12/1946

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2003 Whispering Ponds Court, 3-B

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. Air Force

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

consultant

16b. Kind of Business Industry

Verizon

17. Father's Name (First, Middle, Last)

Edward Kisly

18. Mother's Name (First, Middle, Maiden Surname)

Ilene Balicki

19a. Informant's Name/Relationship (Type, Print)

Judie A. Kisly/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2003 Whispering Ponds Ct, 3-B, Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

2/4/2011

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

David A. Thompson CFSP

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEPATIC FAILURE

Due to (or as a consequence of): ALCOHOL ABUSE

Approximate Interval Between Onset and Death

MONTHS

b. RENAL FAILURE

Due to (or as a consequence of): HEPATIC FAILURE

WEEKS

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nick Goehner MD

29c. License number

1134446164

29d. Date signed (Month, Day, Year)

FEBRUARY 2, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHOLAS GOEHNER, MD 22 SOUTH GREENE ST, BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Anna B. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
RegistrarState of Maryland / Department of Health and Mental Hygiene  
Amend Items 23a Pt I, 25 per me, g913/03/10/2011 dnb  
Certificate of Death

Reg. No.

2011 05657

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joni Lynn Carty Knott

2. Date of Death

February 2, 2011

3. Time of Death

12:30 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

10321 Bethel Road

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

213-72-8088

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
June 25, 1967

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10321 Bethel Road

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business Industry

Recreational vehicles

17. Father's Name (First, Middle, Last)

Edwin L. Carty

18. Mother's Name (First, Middle, Maiden Surname)

Geraldine Scott

19a. Informant's Name/Relationship (Type, Print)

Darlene Carty - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 Claires Way, Fredericksburg, Pennsylvania 17026

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial

Date

2-8-2011

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

*Sharon Camille Coline*

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SUB ARACNOID Hemorrhage

Approximate Interval Between Onset and Death

a. Due to (or as a consequence of):

Cerebrovascular Accident

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Eugene B. Casagrande*

29c. License number

D40307 MD

29d. Date signed (Month, Day, Year)

Feb 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Casagrande

1564 Opossumtown Pike, Frederick, Maryland 21702

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

*Sharon B. Spake*State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit#23a Pt I fax to me  
Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05658

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pamela Elizabeth Kloman

2. Date of Death

Month Day Year  
February 2, 2011

3. Time of Death

10:45 A<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

803 Gabriel Court

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

213-58-0811

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 26, 1951

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

803 Gabriel Court

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Psychiatric Care

17. Father's Name (First, Middle, Last)

Henry Merritt Cunningham

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Mary Obrien

19a. Informant's Name/Relationship (Type, Print)

Andrew Kloman / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

355 Eye St. SW, Unit 307, Washington, DC 20024

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenmount Crematory

Date

Feb. 5, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Resthaven Funeral Services, Skkot Cody P.A.  
9501 Catocin Mountain Hwy. Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

b. Morbid Obesity

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
1 Day

Years

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis, Hepatitis C, Diabetes,

Heart Disease with Chronic Heart Failure, CKD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 24382

29d. Date signed (Month, Day, Year)

Feb 3, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Janet L. Ciarkowski, M.D. 9093 Ridgefield Dr. #104, Frederick, MD 21704

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Janet L. Ciarkowski

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05659

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
Alfred Joseph Kral2. Date of Death  
Month Day Year  
Jan 28 20113. Time of Death  
S:35 P MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

St Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

212-30-5459

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/15/1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

707 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Repairman

16b. Kind of Business Industry

Telephone

17. Father's Name (First, Middle, Last)

Andrew John Kral

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Bessie Seligman

19a. Informant's Name/Relationship (Type, Print)

Diana Hudson Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

923 Topmast Way Annapolis, MD 21401

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lakemont Memorial

Date

2/1/2011

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

Diana Hudson

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Diana Hudson MD

29c. License number

D58571

29d. Date signed (Month, Day, Year)

Jan 29, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lynn Tao

900 Caton Avenue

Baltimore Maryland

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

Lynn B. Sparks

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

CH 6



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05660

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul, Lane

2. Date of Death

Month

Day

Year

3. Time of Death

22:25 M

4a. Facility Name (if not institution, give street and number)

UMMC

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-26-2656

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

November 13, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Ridgely

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11410 Central Avenue

10f. Zip Code

21660

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates to 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Painter/Carpenter

16b. Kind of Business Industry

Construction

17. Father's Name (First, Middle, Last)

Willard Earl Lane

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Lee Covey

19a. Informant's Name/Relationship (Type, Print)

Richard Lane/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8285 Mueller Drive, Easton, Maryland 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Denton Cemetery

Date

Feb. 9, 2011

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee

Raulo... Name

22. Name and Address of Facility

Moore Funeral Home, P.A.  
12 South Second Street, Denton, Maryland 21629

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Aortic dissection

b. Due to (or as a consequence of):

Abdominal aortic aneurysm

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DDA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

O. Tannous

29c. License number

1285952655

29d. Date signed (Month, Day, Year)

2/5/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oliver Tannous, MD 22 S. Greene St, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

James B. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05661

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vernon Julian LEWIS Sr.

2. Date of Death

Month 2 Day 9 Year 2011

3. Time of Death

10:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Ravenwood Lutheran Village

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

181-14-8474

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 21, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19800 Tranquility Circle

10f. Zip Code

21742

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

transportation manager

16b. Kind of Business/Industry

aircraft industry

17. Father's Name (First, Middle, Last)

Julian Burton Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Mary O'Dell Brookman

19a. Informant's Name/Relationship (Type, Print)

Vernon J. Lewis, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

125 Hebb Rd., Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mine Road Baptist Ch. Cem. 2/12/11

Date

20c. Location - City or Town, State

Spotsylvania, Va.

21. Signature of Funeral Service Licensee

Scott M. Minnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mangin J. Shaf

29c. License number

D28635

29d. Date signed (Month, Day, Year)

2-10-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mangin J. Shaf 368 mill street Hagerstown MD 21740

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Dennis A. Spivey

State  
Registrar

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05662

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther May LONG

2. Date of Death

February 6, 2011

3. Time of Death

5:55A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

932 Chestnut Street

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

215-26-8876

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 11, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

932 Chestnut Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Her own home

17. Father's Name (First, Middle, Last)

Ralph Clevenger

18. Mother's Name (First, Middle, Maiden Surname)

Grace Marie Walck

19a. Informant's Name/Relationship (Type, Print)

Betty Thomas - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 N. Edgewood Drive, Apt. 8, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park

Date

2/9/11

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart failure

Due to as a consequence of:

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hypertensive heart disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure

chronic lymphocytic leukemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cynthia Kuttner-Sand, MD

29c. License number

D47451

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Kuttner-Sand, MD Hospice of Washington County, 747 Northern Avenue, Hagerstown, Maryland 21742

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05663

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIS FREDERICK LEISTER III

2. Date of Death

Month  
FEBDay  
03Year  
2011

3. Time of Death

17:00 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

UNIVERSITY of MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

219-25-9239

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

25 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 21, 1985

9. Birthplace (State or Foreign Country)

BALTIMORE, MD

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9511 BANTRY ROAD

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SOUS CHEF

16b. Kind of Business Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

LOUIS FREDERICK LEISTER, II

18. Mother's Name (First, Middle, Maiden Surname)

CHRISTINE SUSAN MOTTER

19a. Informant's Name/Relationship (Type, Print)

LOUIS FREDERICK LEISTER, II/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9511 BANTRY ROAD, EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OXFORD CEMETERY

Date

FEBRUARY 8, 2011

20c. Location - City or Town, State

OXFORD, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.  
408 S. LIBERTY ST., CENTREVILLE, MD 21617

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON SEMINOMATOUS GERMINAL CELL CAUCER - METASTATIC

Due to (or as a consequence of):

b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P24346

29d. Date signed (Month, Day, Year)

FEB 03, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene St. Baltimore, MD 21201 / Christopher Koltz

31. Date filed (Month, Day, Year)

FEB - 7 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit2  
KgState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2011 05664

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Harrison Lyles, Jr.

2. Date of Death

Month Day Year  
Feb. 3, 20113. Time of Death  
6:10P M

4a. Facility Name (if not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

218-38-1650

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 20, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11463 Applegarth Way

10f. Zip Code

20876

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Technician

16b. Kind of Business Industry

Solid Waste

17. Father's Name (First, Middle, Last)

William Harrison Lyles, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Clementine Venters

19a. Informant's Name/Relationship (Type, Print)

Kevin L. Jackson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11463 Applegarth Way, Germantown, Maryland 20876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematorium 2/13/2011 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert L. Williams

22. Name and Address of Facility

Molesworth-Williams P.A., Funeral Home  
26401 Ridge Road, Damascus, Maryland 2087223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. LUNG CANCER  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Santosh Rane MD

29c. License number

D068178

29d. Date signed (Month, Day, Year)

FEBRUARY, 04, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTOSH RANE MD 9901 MEDICAL CENTER DRIVE ROCKVILLE MD

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Santosh Rane

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

2011 05665

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Marcy Lucado

2. Date of Death

February 2 2011

3. Time of Death

5:45 P M

4a. Facility Name (if not institution, give street and number)

Casey House Hospice

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

246-58-4865

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr. 27 1938

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18413 Bowie Mill Road

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Librarian

16b. Kind of Business Industry

Library

17. Father's Name (First, Middle, Last)

Willard Mangrum, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Taylor

19a. Informant's Name/Relationship (Type, Print)

Andrea Mohr / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21211 Denit Estates Drive, Brookeville, Md. 20833

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Norbeck Mem. Park

Date

2/05/11

20c. Location - City or Town, State

Olney, Maryland

21. Signature of Funeral Service Licensee

Roy W. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home  
P. O. Box 5038, Laytonsville, Md. 20882

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Lung Cancer

Approximate Interval Between Onset and Death  
months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. Coleman

29c. License number

D 37142

29d. Date signed (Month, Day, Year)

2-3-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. Coleman, M.D.

1355 Piccard Drive, Rockville, Md. 20850

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Roy W. Barber

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05666

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

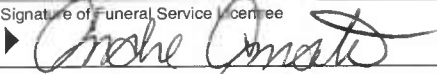


Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Thelma Kruesse Leary</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>2:52A</b> M   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Charlestown</b>   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>224-60-7406</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>01/28/1913</b>                | 9. Birthplace (State or Foreign Country)<br><b>NY</b>  |  |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Catonsville</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>715 Maiden Choice Lane</b>  |  | 10f. Zip Code<br><b>21228</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>   |  | 16b. Kind of Business/Industry<br><b>National Park Service</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Kruesse</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Day</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marcia Dudley - Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3262 Gwenlee Circle Glenwood, MD 21738</b>  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenwood Mem. Grdns.</b>  |   | 20c. Location - City or Town, State<br><b>02/12/2011 Goochland, VA</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Dementia</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>9 Unknown                        |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br> MD  |  | 29c. License number<br><b>D 47009</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Feb 8, 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Phillip Stone, 711 Maiden Choice Lane, Baltimore, MD 21228</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br>  |   |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05667

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Larry Eugene Linkous

2. Date of Death

February 2 2011

3. Time of Death

8 p M

4a. Facility Name (if not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

213-42-6709

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 18, 1944

9. Birthplace (State or Foreign Country)

Riverdale, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brentwood

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3505 Upshur Street

10f. Zip Code

20722

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business Industry

Industrial

17. Father's Name (First, Middle, Last)

Eugene Linkous

18. Mother's Name (First, Middle, Maiden Surname)

Helen Cline

19a. Informant's Name/Relationship (Type, Print)

Mary C. Linkous / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3505 Upshur Street, Brentwood, MD 20722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

2/7/2011

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

4739 Baltimore Avenue

Gasch's Funeral Home, P.A. Hyattsville, MD 20781

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

3 MONTHS

c. HYPERTENSION

5 YEARS

d. DIABETES MELLITUS

5 YEARS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE GASTRITIS

RENAL FAILURE

HYPOTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D19897

29d. Date signed (Month, Day, Year)

2.3.11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. SINGH 7209A HANOVER PKWY GREENBELT MD 20770

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

[Signature]

Linkous, Larry  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05668

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dorothea Marsh</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>1507 M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>10800 Indian Head Highway</b>  |  | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |  |
| 5. Social Security Number<br><b>492-38-0949</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Nov. 13, 1935</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Arkansas</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PG</b>  |  | 10c. City, Town or Location<br><b>Fort Washington</b>  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>10800 Indian Head Highway</b>  |  | 10f. Zip Code<br><b>20744</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self-Employed</b>   |  | 16b. Kind of Business Industry<br><b>Owner</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ora Guy</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Opal Dixon</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Felicia Marsh/daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>357 Wesmond Drive Alexandria, VA 22305</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Golden Gate Funeral Home &amp; Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Dallas, TX</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Janice Edwards</b>  |  | 22. Name and Address of Facility<br><b>Hodges &amp; Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>c. <b>Respiratory Failure</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Paraplegia</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Stuart A. Meyers M.D.</b>   |  | 29c. License number<br><b>01010322131</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/18/11</b>   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STUART A. MEYERS, MD, 1502 Featherstone Rd, Woodbridge, VA 22191</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br><b>Janice Edwards</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Certificate of Death

Reg. No. 2011 05669

1- For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWA KAY MILLER

2. Date of Death  
Month Day Year

1

4

11

3. Time of Death  
10:57 AM

4a. Facility Name (if not institution, give street and number)

406 East Fourth Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

224-70-8450

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 31, 1945

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

215 Humbird Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

Cletus Self

18. Mother's Name (First, Middle, Maiden Surname)

Ethel (Miller) Kincaid

19a. Informant's Name/Relationship (Type, Print)

Michael Crawford son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

406 East Fourth Street Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

1/7/2011

20c. Location - City or Town, State

Cumberland MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA  
108 Virginia Avenue, Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PROBABLY ARTERIOPLASMIA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

son's residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

KATE TULLY MD

29c. License number

D29301

29d. Date signed (Month, Day, Year)

1-4-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATE TULLY 621 KELLY RD CUMBERLAND MD 21502

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

LAWA KAY MILLER

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05670

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Keith Mitchell

2. Date of Death

February 1, 2011

3. Time of Death

1702 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

31364 George Mitchell Lane

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

214-68-6865

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

01/31/1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

31364 George Mitchell Lane

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

owner/operator

16b. Kind of Business Industry

small engine repair

17. Father's Name (First, Middle, Last)

Preston Edward Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

June Elizabeth Pope

19a. Informant's Name/Relationship (Type, Print)

Quentin Mitchell/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31364 George Mitchell Lane, Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Mitchell Family  
Cemetery

Date

2/7/2011

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Kane L. A.

22. Name and Address of Facility

Bollway Funeral Home Professional Association  
501 Snow Hill Rd. Salisbury, MD 2180423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Complication of Pancreatic Cancer

Approximate  
Interval Between  
Onset and Death

2

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chris Snyder D.O. DME

29c. License number

H50491

29d. Date signed (Month, Day, Year)

2/3/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chris Snyder D.O. DME 100 E Carroll St. Salisbury MD 21801

31. Date filed (Month, Day, Year)

FFR 04 2011

32. Registrar's Signature

A. H. H. H.

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05671

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Matthew Moore, Jr.

2. Date of Death

February 7, 2011

3. Time of Death

9:23A M

4a. Facility Name (if not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

240-72-4565

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

8. Date of Birth

01-21-1945

9. Birthplace (State or Foreign Country)

No. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7610 Oxman Road

10f. Zip Code

20875

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Burner Operator

16b. Kind of Business Industry

Private Industry

17. Father's Name (First, Middle, Last)

Matthew Moore, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Armstrong

19a. Informant's Name/Relationship (Type, Print)

Linda A. Moore (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7610 Oxman Road Hyattsville, Maryland 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cem.

Date

02-15-2011

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Ralph Williams, II

22. Name and Address of Facility

Ralph Williams, II Funeral Service, P.A. 5202 Princetons Delight Dr., Bowie, MD 20720

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Myeloma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter on separate lines.

Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy  
Chronic Kidney Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident 6 ☐ Investigation3 ☐ Suicide 6 ☐ Could not be determined4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ralph Williams, II

29c. License number

D45660

29d. Date signed (Month, Day, Year)

2-8-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300, CALLANT FOX LN, 24 Bowie MD 20711

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

James D. Parker

State  
Registrar

Moore, Matthew  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05672

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lillian L J Makle

2. Date of Death

Month 2 Day 7 Year 11

3. Time of Death

12:40 PM

4a. Facility Name (if not institution, give street and number)

Fort Washington Medical

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George

5. Social Security Number

577-32-9885

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4-26-23

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8600 Milke Shapiro Dr. #605

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business Industry

Humemaker

17. Father's Name (First, Middle, Last)

James Johnson Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Fowler

19a. Informant's Name/Relationship (Type, Print)

Lillian P. Smith - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8266 Woody Rd, Port Tobacco MD 20677

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan

Date

2-9-11

20c. Location - City or Town, State

Alexandria VA

21. Signature of Funeral Service Licensee

Theresa Neal

22. Name and Address of Facility

Adams Funeral Home Ps, Agasson MD 20608

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Cardiovascular Disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia  
Recent Stroke  
Sacroiliac Degenerative Ulcer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Edgar Potter

29c. License number

D42955

29d. Date signed (Month, Day, Year)

2/5/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12011 Ft Washington Rd. Ft Washington, Md

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

Lenna S. Jones

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Certificate of Death

Reg. No.

2011 05673

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Samuel McCutcheon

2. Date of Death

February 13 2011

3. Time of Death

9:00 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Frostburg Village Nursing Center

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

5. Social Security Number

217-10-7681  
7568

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 29 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Lonaconing

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22204 Seldon Seen Road

10f. Zip Code

21539

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Pipe Fitter Helper

16b. Kind of Business Industry

Fiber Manufacturer

17. Father's Name (First, Middle, Last)

Samuel McCutcheon

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Fairgrieve

19a. Informant's Name/Relationship (Type, Print)

Vivian McCutcheon/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22204 Seldon Seen Road, Lonaconing Maryland 21539

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. View Cemetery

Date

02/16/2011

20c. Location - City or Town, State

Barton, Maryland

21. Signature of Funeral Service Licensee

7/2/2011

22. Name and Address of Facility

Boal Funeral Home

111 Church St., Westernport, Maryland 21562

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hty pertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Jesus Tan

29c. License number

D21244

29d. Date signed (Month, Day, Year)

2/14/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jesus Tan, 4 Broadway, Frostburg, MD 21532

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Jesus A. Tan

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05674

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Joan Catherine Murray

2. Date of Death

Month  
02Day  
09Year  
2011

3. Time of Death

8:00 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Dennett Road Nursing Home

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

185-24-4429

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

08 04 1930

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1113 Mary Drive

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Operator

16b. Kind of Business Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Joseph Paul McSorley

18. Mother's Name (First, Middle, Maiden Surname)

Ella Regina Smithmyer

19a. Informant's Name/Relationship (Type, Print)

James Murray-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

94 Ridge Crest Road, Oakland, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garr. Co Memorial Gardens

Date

2/12/2011

20c. Location - City or Town, State

Oakland, MD

21. Signature of Funeral Service Licensee

David A. Burdock

22. Name and Address of Facility David A. Burdock Funeral Home, P.A.

21 N. 2nd St., Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

severe COPD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

fjk

29c. License number

D15333

29d. Date signed (Month, Day, Year)

2/11/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Thomas G. Johnson

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

5

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2011 05675

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN A. MCHUGH

2. Date of Death  
Month Day Year

2/3/2011 12:10 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

170-32-1164

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

9/23/1940

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

1740 Tedbury St.

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Insurance Billing Specialist

16b. Kind of Business Industry

Medical

17. Father's Name (First, Middle, Last)

Mickal Madar

18. Mother's Name (First, Middle, Maiden Surname)

Susan Magura

19a. Informant's Name/Relationship (Type, Print)

Joseph B. McHugh / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1740 Tedbury St., Crofton, MD 21114

20a. Method of Disposition  
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

2/4/2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Beall Funeral Home

6512 NW Crain Hwy., Bowie, MD 20715

Physician/  
Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. METASTATIC LUNG CANCER

Approximate  
Interval Between  
Onset and Death  
MONTHSSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_\_  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

26. Place of Death (Check only one)  
1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

G. L. Taylor Np

29c. License number

R118703

29d. Date signed (Month, Day, Year)

2/4/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GENEVIEVE LIGHTFOOT-TAYLOR, 445 DEFENSE HWY, ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Anna B. Sparks

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>William Aldis Mayhew, Jr.</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>3</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>2:01 P. M</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>9207 Tuckerman Street</b>  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |   | 4c. County of Death<br><b>Prince George's</b>   |   |
| 5. Social Security Number<br><b>116-22-3219</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 24, 1932</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Florida</b>  |
| Usual Residence of Decedent   |  |   |   |   |   |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>                                      | 10c. City, Town or Location<br><b>Lanham</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>9207 Tuckerman Street</b>  |  | 10f. Zip Code<br><b>20706</b>   |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>1954-74</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Meteorologist</b>   |   |
| 16b. Kind of Business Industry<br><b>U. S. Federal Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William Aldis Mayhew, Sr.</b>   |   |   |   |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Butler Cornell</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Johnnetta Mayhew/Wife</b>  |   |   |   |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9207 Tuckerman Street, Lanham, Maryland 20706</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Conation <input type="checkbox"/> Other (Specify)   |   |   |   |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National</b>   |  | Date<br><b>3/2/2011</b>   |   | 20c. Location - City or Town, State<br><b>Arlington, VA</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home<br/>16000 Annapolis Road, Bowie, Maryland 20715</b>   |   |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Congestive Heart Failure</b>   |  |   |   |   | Approximate Interval Between Onset and Death  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |   |   |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>g <input type="checkbox"/> Unknown  |  |   |   |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br>g <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year   |  |   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> COA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D23743</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 4, 2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Martin Weltz, 7525 Greenway Court, Greenbelt, Maryland 20770</b>   |  |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 2011</b>   |  | 32. Registrar's Signature<br>   |   |   |   |

1- For AMEND#18 per FH  
State Registrar 2/7/2011

ACO HEALTH DEPT. OMH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2011 05677

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Dolores Monch

2. Date of Death

Month 2 Day 2 Year 11

3. Time of Death

7:50 PM

4a. Facility Name (If not institution, give street and number)

Genesis Spa Creek Cntr

4b. City, Town, or Location of Death

Annapolis md

4c. County of Death

Anne Arundel

5. Social Security Number

216-16-6083

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

2-29-24

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1201 Sterling Drive

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Hotel Owner

16b. Kind of Business Industry

Hospitality

17. Father's Name (First, Middle, Last)

Herbert Sadler

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Paeks Gladys Parks

19a. Informant's Name/Relationship (Type, Print)

Daniel Monch - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1201 Sterling Dr, Annapolis, MD 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hillcrest Mem Gardens

Date

2/8/2011

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee

Stephen T. Klobert

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St, Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Dementia

b. Due to (or as a consequence of):

Failure to thrive

c. Due to (or as a consequence of):

Pancreatitis

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hunt Davis MD

29c. License number

D53111

29d. Date signed (Month, Day, Year)

2/3/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUNT DAVIS, 2007 TIDEWATER COLONY 1-A, ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Kenna B. Sparks

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05678

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE JEFFERSON MOORE

2. Date of Death

FEB. 1, 2011

3. Time of Death

3:25 A M

4a. Facility Name (if not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

245-16-0665

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

8. Date of Birth

AUG. 29, 1921

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9701 VEIRS DRIVE

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YRS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CIVIL ENGINEER

16b. Kind of Business Industry

ENGINEERING

17. Father's Name (First, Middle, Last)

JAMES ROBERT MOORE, JR.

18. Mother's Name (First, Middle, Maiden Surname)

NANNIE AMANDA BOWMAN

19a. Informant's Name/Relationship (Type, Print)

MRS. ROBIN KURTZMAN-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7512 GRANADA DRIVE, BETHESDA, MD. 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METROPOLITAN CREM.

Date

2/2/2011

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensed

WILLIAM H. HONG

22. Name and Address of Facility

HYSONG CO., INC.

2222-WISCONSIN AVE., NW

WASHINGTON, D.C. 20007

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMERS DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Yes 4 ☐ No

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident 6 ☐ Investigation3 ☐ Suicide 6 ☐ Could not be determined4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

WILLIAM H. HONG

29c. License number

D0057158

29d. Date signed (Month, Day, Year)

FEBRUARY 1, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VADIA ANDREY 9701 VEIRS DR ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Kenna D. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

33

State  
Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2011 05679

1- For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>George Nichols</i>   |  |   |  | 2. Date of Death<br>Month <i>January</i> Day <i>29</i> Year <i>2011</i>   |  |   |  | 3. Time of Death<br><i>13:45 PM</i>   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><i>Johns Hopkins Bayview Medical Center</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  |   |  | 4c. County of Death   |  |  |  |
| 5. Social Security Number<br><i>219-36-5682</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><i>71</i> Yrs.  |  | 8. Date of Birth<br>Month <i>11</i> Day <i>20</i> Year <i>1939</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>   |  |  |  |
| 10a. State<br><i>Maryland</i>   |  |   |  | 10b. County<br><i>Wicomico</i>  |  | 10c. City, Town or Location<br><i>Salisbury</i>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><i>1018 Pierce Ave.</i>   |  |   |  | 10f. Zip Code<br><i>21804</i>   |  |   |  | 10g. Citizen of What Country?<br><i>USA</i>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <i>Navy</i> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>white</i>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>-</i>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>supervisor</i>  |  |   |  | 16b. Kind of Business Industry<br><i>pump manufacturing</i>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Marion L. Nichols</i>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Virginia Lee Pilchard</i>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Joyce Nichols/spouse</i>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1018 Pierce Ave., Salisbury, MD 21804</i> |  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Springhill memory gardens</i>  |  | Date<br><i>2/3/2011</i>   |  | 20c. Location - City or Town, State<br><i>Hebron, MD</i>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  |   |  | 22. Name and Address of Facility<br><i>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</i>          |  |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cardio-pulmonary failure</i><br>Due to (or as a consequence of):<br>b. <i>Multi-system organ failure</i><br>Due to (or as a consequence of):<br>c. <i>3rd Degree burn to chest and right arm</i><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><i>48 hrs</i><br><i>20 days</i><br><i>24 days</i> |  |   |  |   |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of injury (Month, Day, Year)<br><i>Jan 3, 2011</i>  |  | 28b. Time of injury<br><i>unknown</i>   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><i>Subject fell onto space header</i>                     |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><i>Home</i>   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>1018 Pierce Ave Salisbury MD</i>   |  |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                           |  |   |  | 29b. Signature and title of certifier<br><i>[Signature] D.O.</i>  |  |   |  | 29c. License number<br><i>RIE-000</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>January 29 2011</i>                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Asa Margolis 4940 Eastern Avenue, Baltimore, MD 21224</i>  |  |   |  |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 04 2011</i>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05680

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Ganell Norris

2. Date of Death

February 8 2011

3. Time of Death

7:20 P.M.

4a. Facility Name (If not institution, give street and number)

Fahrney-Keedy Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-26-5132

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 28, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Keedysville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

60 North Main Street

10f. Zip Code

21756

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business Industry

Home

17. Father's Name (First, Middle, Last)

Lewis G. Giffin

18. Mother's Name (First, Middle, Maiden Surname)

Maude Gladys Benner

19a. Informant's Name/Relationship (Type, Print)

Glenda E. Norris - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

60 North Main Street Keedysville, Maryland 21756

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairview Cemetery

Date

02-12-2011

20c. Location - City or Town, State

Keedysville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Osborne Funeral Home, P.A.  
425 S. Conococheague St. Williamsport, MD 21795

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

15x

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P52323

29d. Date signed (Month, Day, Year)

02-09-2011

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Khalid M. Waseem MD 1126 Opal Court Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Pauline Norris  
Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene


## Certificate of Death

Reg. No.

2011 05681

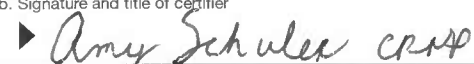

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Catherine Ann Nehouse</b>  |  |   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>5</b> Year <b>2011</b>  |                                | 3. Time of Death<br><b>2:30 a<sup>M</sup></b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Lorien Mt. Airy ALF</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Mt. Airy</b>  |                                | 4c. County of Death<br><b>Carroll</b>  |  |
| 5. Social Security Number<br><b>219-48-3123</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>12/15/1922</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Mt. Airy</b>   |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>713 Midway Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21771</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                | 16b. Kind of Business Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Moulden</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Catherine Hale</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary C. Milone/Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28867 Lakeview Rd., Millsboro, DE 19966</b>  |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salem UMC Cem.</b>   |  | Date<br><b>2/11/11</b>   |                                | 20c. Location - City or Town, State<br><b>Germantown, MD</b>                                       |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Raymond-Wood F.H., P.A.<br/>PO Box 430, Dunkirk, MD 20754</b>   |                                |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |
|---|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>5 years</b><br><b>2 weeks</b>  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)<br><br>28b. Time of injury<br><b>M</b><br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br><br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>R118354</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/6/2011</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Amy Schuler CRNP 7900 Oak Point Ct. Pasadena, MD 21122</b>   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB - 8 2011</b>  |  | 32. Registrar's Signature<br>   |  |

State  
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05682

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Elwood OHLER

2. Date of Death

Month FEB Day 7 Year 2011

3. Time of Death

8:30 P M

4a. Facility Name (if not institution, give street and number)

1043 Spruce Street

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

216-22-8353

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 27 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1043 Spruce Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business Industry

Metal works

17. Father's Name (First, Middle, Last)

Grover Melroy Ohler

18. Mother's Name (First, Middle, Maiden Surname)

Mary Sherley

19a. Informant's Name/Relationship (Type, Print)

Claudine Ohler - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1043 Spruce Street, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

2/9/2011

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Minnick

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

year

year

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Scott M. Minnick MD

29c. License number

20045031

29d. Date signed (Month, Day, Year)

Feb 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARON Z. SIBBOLD 324 E. Gulletan St HAGERSTOWN MD 21740

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

Anne S. Park

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2011 05683

1- For State  
Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner  
  
  
Funeral  
Director

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>STEWART EDWARD PARROTT</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 26, 2011</b>  |  | 3. Time of Death<br><b>1020 hrs</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>1103 State Street</b>  |  | 4b. City, Town, or Location of Death<br><b>Delmar</b>  |  | 4c. County of Death<br><b>Wicomico</b>   |   |
| 5. Social Security Number<br><b>219-862559</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.   |   |
| 8. Date of Birth (MM/DD/YYYY)<br><b>8-9-1963</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |  |   |
| Usual Residence of Decedent   |  |  |  |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Wicomico</b>   |  | 10c. City, Town or Location<br><b>DELMAR</b>   |   |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |   |
| 10e. Street and Number<br><b>1103 E. STATE ST.</b>  |  | 10f. Zip Code<br><b>21875</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>AUTO BODY REPAIR</b>   |  | 16b. Kind of Business/Industry<br><b>AUTO BODY</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES HOPPER PARROTT SR</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHIRLEY HOLLOWETH</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James Parrott Brother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3903 GREENHILL CHURCH RD OAKTON MD 21856</b>   |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SAUSBURY crematory 2-4 11</b>   |  | 20c. Location - City or Town, State<br><b>SAUSBURY, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b> M00295  |  | 22. Name and Address of Facility<br><b>Hinman Funeral Home, PA<br/>11673 Somerset Avenue, Princess Anne, Md. 21853</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Cocaine and narcotic (heroin) intoxication</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Due to (or as a consequence of):<br><input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED<br><b>23a, 27, 28a-f, per ME g913 3/3/11 TT</b> |  |  |  |  | Approximate Interval Between Onset and Death  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |  |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Fd 1/26/11</b>  |  | 28b. Time of Injury<br><b>Fd 10:15 am</b>  |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>unk</b>  |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>residence</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1103 State St Delmar, MD</b>  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Theodore M. King, Jr., MD</b>   |  | 29c. License number<br><b>O.C.M.E. OCME</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>January 27, 2011</b>   |   |
| 30. Name and address of person who completed cause of death (Rem 23a)<br><b>Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 24 2011</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05684

1- For  
State  
Registrar

|  |   |  |   |  |   |  |  |  |
|--|---|--|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eugene Vincent Phelps</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>10</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>1745 M</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>   |  | 4c. County of Death<br><b>Talbot</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-16-7642</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>85</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 7, 1925</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Caroline</b>  |  | 10c. City, Town or Location<br><b>Denton</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>27277 Burrsville Road</b>  |  | 10f. Zip Code<br><b>21629</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1943</b><br>If Yes, Give Year or Dates <b>to 1971</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>11 H.S. Grad.</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Well driller</b>  |  | 16b. Kind of Business Industry<br><b>Water</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Thomas Edward Phelps</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula Goswellen</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cheryl Voorhees/daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27277 Burrsville Road, Denton, Maryland 21629</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory</b>  |  | Date<br><b>Feb. 11, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Dover, Delaware</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>Moore Funeral Home, P.A.<br/>12 South Second Street, Denton, Maryland 21629</b>  |  |   |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):<br>b. <b>pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Atrial Fibrillation</b><br>Due to (or as a consequence of):<br>d. <b>hypertension</b> |  |   |  |   |  |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   | 29a. Certifier<br>(Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> <b>M.D.</b>  |   | 29c. License number<br><b>57,546</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2/10/11</b>  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ignacio L. B. ... M.D. EmH (Easton mem. Hptl)</b>   |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 2011</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitPhelps, Eugene  
Baltimore, Maryland 21215-0036permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05685

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Melvin Leonard Patchett, Sr.

2. Date of Death

Month  
FebDay  
4Year  
2011

3. Time of Death

2:00 PM

4a. Facility Name (If not Institution, give street and number)

Genesis HealthCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

219-07-0912

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 1, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

610 Dutchman's Lane

10f. Zip Code

21601

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Motor Equipment Operator

16b. Kind of Business/Industry

MD State Highway Dept.

17. Father's Name (First, Middle, Last)

Robert Duke Patchett

18. Mother's Name (First, Middle, Maiden Surname)

Ella Eberhardt McPheeters

19a. Informant's Name/Relationship (Type, Print)

Donna B. Dixon/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29620 Dover Acres Road, Easton, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Spring Hill Cemetery

Date

02/08/11

20c. Location - City or Town, State

Easton, Maryland

21. Signature of Funeral Service Licensee

Christine M. Coale

22. Name and Address of Facility

Frampton Funeral Home, PA

216 N. Main St., Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Fatal arrhythmia

Due to (or as a consequence of):

b.

Atrial fibrillation

Due to (or as a consequence of):

c.

Atherosclerosis, generalized

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

minutes

years

years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DCA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Crowley, MD

29c. License number

DZ5933

29d. Date signed (Month, Day, Year)

2.4.2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL CROWLEY, MD 610 DUTCHMAN'S LANE EASTON, MD 21601

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

Melvin Patchett  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05686

1- For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roger Perdue Pusey

2. Date of Death

February 7, 2011

3. Time of Death

0505 M

4a. Facility Name (if not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

212-32-2982

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

78

8. Date of Birth (Month, Day, Year)

May 12, 1932

9. Birthplace (State or Foreign Country)

Snow Hill, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Snow Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5457 Market Street

10f. Zip Code

21863

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No 1955-  
If Yes, Give Year or Dates. 1957

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

horse trainer

16b. Kind of Business Industry

equestrian

17. Father's Name (First, Middle, Last)

Fred C. Pusey

18. Mother's Name (First, Middle, Maiden Surname)

Cora Virginia Perdue

19a. Informant's Name/Relationship (Type, Print)

Elizabeth P. Wooten (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5457 Market Street Snow Hill, MD 21863

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Whatcoat Cemetery Feb. 11, 2011 Snow Hill, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Short Funeral Home

13 East Grove Street Delmar, DE 19940

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] J. van Edmond MD

29c. License number

D56307

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. van Edmond MD, Atlantic General Hospital, 9733 Healthway Dr., Berlin, MD 21811

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 MD  
1 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05687

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JERRY AZPIONISO PRATT

2. Date of Death

Month 02 Day 03 Year 11

3. Time of Death

0704M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

217-62-9713

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr 16 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

960 President St. Apt 3B

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business Industry

West Street

Service Center

17. Father's Name (First, Middle, Last)

Arthur Pratt

18. Mother's Name (First, Middle, Maiden Surname)

Priscilla Sharps

19a. Informant's Name/Relationship (Type, Print)

Kittorra Pratt (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1038 Jack Place Baltimore, Md. 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

2-10-11

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Larry H. Reese 160483

Name of Facility

821 West St. Annapolis, Md. 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Renal Failure

Approximate Interval Between Onset and Death

Days

a. Due to (or as a consequence of):

CA BLADDER

Months

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael J. Lapenta

29c. License number

D21438

29d. Date signed (Month, Day, Year)

February 03 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LAPENTA 445 DEFENSE HWY ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Anna B. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05689

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Lynn Pressler

2. Date of Death

February 7 2011

3. Time of Death

1:32 p M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216-48-0080

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

04/01/1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10228 Bristol Channel

10f. Zip Code

21042

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

17. Father's Name (First, Middle, Last)

John V. Rickle

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Gernershausen

19a. Informant's Name/Relationship (Type, Print)

Donald J. Pressler - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10228 Bristol Channel Ellicott City, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cem.

Date

02/11/2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

► Andrew P. Gato M00845

22. Name and Address of Facility

Harry H. Witzke's Family F.H.Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA OF LOWY BODY TYPE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature] MD

29c. License number

046360

29d. Date signed (Month, Day, Year)

FEBRUARY 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL A. ANJEROM MD 6701 NORTH CHARLES STREET BALTIMORE MD 21204

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05690

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Latoya Palmer

2. Date of Death

Month Day Year  
Jan 26 2011

3. Time of Death

6:46 PM

4a. Facility Name (if not institution, give street and number)

University of Maryland, Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-65-3946

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

31

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DECEMBER 31 1979 JAMAICA

9. Birthplace (State or Foreign Country)

JAMAICA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

902 MINNA AVENUE

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business Industry

PRIVATE

17. Father's Name (First, Middle, Last)

ANTHONY SINCLAIR

18. Mother's Name (First, Middle, Maiden Surname)

OLIVE BARKLEY

19a. Informant's Name/Relationship (Type, Print)

LANCELOT PALMER/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

902 MINNA AVENUE CAPITOL HEIGHTS, MARYLAND 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

RIVERDALE CREMATORY

Date

2/7/11

20c. Location - City or Town, State

RIVERDALE, MARYLAND

21. Signature of Funeral Service Licensee

Diane L. Calloway

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME, INC.  
7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line

Immediate Cause (Final  
disease or condition  
resulting in death)a. Sepsis  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Relapse T cell lymphoma  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CMV reactivation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

M

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check

only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lei Jia Chen MD

29c. License number

D71215

29d. Date signed (Month, Day, Year)

01/26/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lei Jia Chen 22 South Greene Street, Baltimore, Maryland, 21201

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

D. J. Parks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05691

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Forrest Russell, Jr.

2. Date of Death

February 6 2011

3. Time of Death

0313 M

4a. Facility Name (if not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

213-24-2588

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

80

8. Date of Birth (Month, Day, Year)

July 10, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Hurlock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4349 Russell Road

10f. Zip Code

21643

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. '55-57

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11 (Grad.)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business Industry

MD State Hwy. Adm.

17. Father's Name (First, Middle, Last)

Forrest D. Russell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Jones

19a. Informant's Name/Relationship (Type, Print)

Bertha Jeanette Russell/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4349 Russell Rd., Hurlock, MD 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Eastern Shore Veterans

Date

02/12/11

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Frampton Funeral Home, PA  
Federalsburg, MD 21632

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis Syndrome

Due to (or as a consequence of):

b. Multiple Myeloma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Days

Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Salmonella colitis  
chronic kidney disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul W. Monte

29c. License number

64043

29d. Date signed (Month, Day, Year)

February 6, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL W. MONTE, MD 219 South Washington St. Easton, MD 02601

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

State  
RegistrarForrest, Russell  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05692

1- For State Registrar

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DERRICK

RICHARDS

2. Date of Death

FEBRUARY 7 2011

3. Time of Death

2:43 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

590-22-8636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

FEB. 26 1969

9. Birthplace (State or Foreign Country)

FLORIDA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

SPRINGDALE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9410 BIEMAN TERRACE

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROJECT MANAGER

16b. Kind of Business Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

WILLIAM RICHARDS JR.

18. Mother's Name (First, Middle, Maiden Surname)

ROBERTA BROWN

19a. Informant's Name/Relationship (Type, Print)

VALERIE RICHARDS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9410 BIEMANS TERRACE SPRINGDALE, MARYLAND 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESURRECTION CEME.

Date

2/14/2011

20c. Location - City or Town, State

CLINTON, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC.

7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiomyopathy*

Due to (or as a consequence of):

b. *Pneumonia*

Due to (or as a consequence of):

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Blank CRNP

29c. License number

R097929

29d. Date signed (Month, Day, Year)

02-07-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Blank CRNP 11701 Livingston Rd. Ft. Washington, MD

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Denise D. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05693

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Rose Ann Rains

2. Date of Death

Month Day Year  
February 7, 2011

3. Time of Death

3:20 A M

4a. Facility Name (if not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

078-16-9879

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

8. Date of Birth (Month, Day, Year)

2/1/1922

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12261 Roundwood Rd., Unit 215

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

16b. Kind of Business Industry

Banking

17. Father's Name (First, Middle, Last)

Frank Montanaro

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Conena

19a. Informant's Name/Relationship (Type, Print)

Linda R. Allman/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3412 Blenheim Rd., Phoenix, MD 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Kalas Crematory

Date

2/8/11

20c. Location - City or Town, State

Edgewater, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Debility  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke, seizure disorder, Urinary tract infection  
Polycythemia vera, CAD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58303

29d. Date signed (Month, Day, Year)

February 7 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNIE J CHARLES MD 6701 N. Charles ST TOWSON MD

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05694

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Frances S. Ray

2. Date of Death  
Month Day Year  
February 2 20113. Time of Death  
2:35p M

4a. Facility Name (If not institution, give street and number)

5702 Ridge Road

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Carroll

5. Social Security Number

243-32-3609

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

Aug. 6, 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5702 Ridge Road

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Administrative Asst. Apsen Publishing

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Benjamin Alfred Sherman

18. Mother's Name (First, Middle, Maiden Surname)

Clyde Mae Wright

19a. Informant's Name/Relationship (Type, Print)

Teresa R. Sipes/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5694 Ridge Road, Mt. Airy, Maryland 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stauffer Crematory Inc. 2/3/2011

Date

20c. Location - City or Town, State

Frederick, Maryland.

21. Signature of Funeral Service Licensee

Teresa R. Sipes

22. Name and Address of Facility

Stauffer Funeral Homes P. A.  
1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis

Hypertension

Parkinson's disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gail T. Griffin MD

29c. License number

MD 55104

29d. Date signed (Month, Day, Year)

2/3/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gail T. Griffin MD 1502 South Main Street, Mt. Airy, Maryland 21771

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Ann S. Spaw

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05695

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome Earl Ransome, Sr.

2. Date of Death

January 27, 2011

3. Time of Death

9:21 a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gladys Spellman Nursing Home

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

215-46-4232

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 12, 1948

9. Birthplace (State or Foreign Country)

Pomfret, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

6503 Cricket Pl.

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

George Oakley Ransome

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Bell

19a. Informant's Name/Relationship (Type, Print)

Tyrome Ransome / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6503 Cricket Pl. Forestville, Md. 20747

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill

Date

2/4/2011

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope, P.A.  
5538 Marlboro Pike/ Forestville, Md. 2074723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Approximate  
Interval Between  
Onset and Death

years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 Yes 2 No  
9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 3 Ectopic pregnancy  
4 Pregnant at time of death 5 Other (specify)  
9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease / Hemodialysis  
Chronic Obstructive Lung Disease  
Aortic Encephalopathy Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an  
autopsy  
performed?  
1 Yes 2 No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 Yes 2 No25. Was case referred to medical  
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident investigation  
3 Suicide 6 Could not be  
4 Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Kenna B. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene  
important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05696

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Steven A Smith

2. Date of Death

Month Day Year  
February 2 2011

3. Time of Death

0156 M

4a. Facility Name (if not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

213-70-9200

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
2-2-1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7474 Rockwalkin Road

10f. Zip Code

21830

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Service Manager

16b. Kind of Business Industry

Burnett White Auto

17. Father's Name (First, Middle, Last)

Frank L.

18. Mother's Name (First, Middle, Maiden Surname)

Smith, Jr.

Joyce

Bailey

19a. Informant's Name/Relationship (Type, Print)

Kristine Smith - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7474 Rockwalkin Road, Hebron, Maryland 21830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springhill Memory Gd

Date

2-5-2011

20c. Location - City or Town, State

Hebron, Maryland

21. Signature of Funeral Service Licensee

Dennis Kelly Larkin

22. Name and Address of Facility

Bounds Funeral Home

705 E. Main Street, Salisbury, Maryland 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Coronary Artery Disease

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey Wickland

29c. License number

D34768

29d. Date signed (Month, Day, Year)

2/3/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Wickland 100 E. Carroll St Salisbury, Md. 21801

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Dennis A. Larkin

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05697

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert I. Snair, Jr.

2. Date of Death

Month 2 Day 1 Year 2011

3. Time of Death

10:18 P M

4a. Facility Name (if not institution, give street and number)

Atlantic General

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

212-30-4706

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

10-21-1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12627 Whisper Trace Drive

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

1953-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Robert I. Snair, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Charch

19a. Informant's Name/Relationship (Type, Print)

Carole Snair, Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12627 Whisper Trace Drive, West Ocean City, MD 21842

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva

Date

2-3-2011

20c. Location - City or Town, State

Delmar, Delaware

21. Signature of Funeral Service Licensed

Melissa Day Blake

22. Name and Address of Facility

Bounds Funeral Home

705 E. Main Street, Salisbury, Maryland 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VALVULAR CARDIAC DISEASE

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

c. HYPERTENSIVE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Arwin Carson

29c. License number

046257

29d. Date signed (Month, Day, Year)

2-3-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arwin Carson, 10374 OLD OCEAN CITY BLVD. BERLIN, MD 21811

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Arwin B. Spauld

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05698

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANN M. SMITH

2. Date of Death

Month Day Year  
JANUARY 31 2011

3. Time of Death

8:25 P M

4a. Facility Name (If not institution, give street and number)

CASEY HOUSE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-36-5734

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 15 1932

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3136 PYLES DRIVE

10f. Zip Code

20774

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

AARON D. TONEY

18. Mother's Name (First, Middle, Maiden Surname)

MARY A. MARCH

19a. Informant's Name/Relationship (Type, Print)

STACY MIDDLETON/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10901 TYRONE DRIVE UPPER MARLBORO, MARYLAND 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

2/4/2011

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Duane L. Callaway

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME, INC.

7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. CHF

Due to (or as a consequence of):

ACUTE RESPIRATORY FAILURE

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Pending Investigation  
3 ☐ Accident 4 ☐ Suicide  
5 ☐ Homicide 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Debrah Miller CNP

29c. License number

R143201

29d. Date signed (Month, Day, Year)

2-1-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBRAH MILLER 6001 MUNCASTER MILL ROAD ROCKVILLE, MARYLAND 20855

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

D. S. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

## Certificate of Death

Reg. No.

2011 05699

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jesse Small, Sr.

2. Date of Death

Month 02 Day 02 Year 2011

3. Time of Death

1733 M

4a. Facility Name (if not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-18-6100

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

01/25/1919

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2010 Upshur Street, NE

10f. Zip Code

20018

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Owner

16b. Kind of Business Industry

Hospitality

17. Father's Name (First, Middle, Last)

Virgil Small

18. Mother's Name (First, Middle, Maiden Surname)

Martha Small

19a. Informant's Name/Relationship (Type, Print)

Lisa Bell-Jones/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7815 Dellwood Ave., Lanham, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

02/11/2011

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

► *Angela Montgomery Cheate*

22. Name and Address of Facility

Ft. Lincoln Funeral Home, Inc.

3401 Bladensburg Road Brentwood, MD 20722

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)a. SEVERE SEPSIS  
Due to (or as a consequence of):b. ACUTE CHOLECYSTITIS  
Due to (or as a consequence of):c. GALL STONE PANCREATITIS  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE,

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check

only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *J. Obadi*

29c. License number

D68005

29d. Date signed (Month, Day, Year)

FEBRUARY 7 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFER OBIADI MD, 7600 CARROLL AVENUE, TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

*James B. Sparks*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05700

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT J. SHRIEVES

2. Date of Death

FEBRUARY 5 2011

3. Time of Death

2:42 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

229-86-1513

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JULY 16 1956

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

WEST HYATTSVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2608 KIRKWOOD PLACE #4

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

AMTRACK PORTER

16b. Kind of Business Industry

PRIVATE

17. Father's Name (First, Middle, Last)

ROBERT SHRIEVES SR.

18. Mother's Name (First, Middle, Maiden Surname)

AZEAL BAKER

19a. Informant's Name/Relationship (Type, Print)

GIFFORD G. SHRIEVES/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3203 W. FRANKLIN STREET #1A RICHMOND, VIRGINIA 23221

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

RIVERDALE CREMATORY

Date

2/12/2011

20c. Location - City or Town, State

RIVERDALE, MARYLAND

21. Signature of Funeral Service Licensee

K. D. M. Hall

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME, INC.

7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY EMBOLISM

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

MULTI ORGAN FAILURE

ACQUIRED IMMUNE DEFICIENCY SYNDROME

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shamir, MD

29c. License number

D-59284

29d. Date signed (Month, Day, Year)

2/11/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAMIR SHAMIR, WASHINGTON ADVENTIST HOSPITAL, TAKOMA PARK

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

P. J. Park

MD-20912

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05701

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VESTA C. SELDEN

2. Date of Death

Month: FEBRUARY 3, 2011 Day: Year:

3. Time of Death

2:40 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

CASEY HOUSE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

578-24-1055

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month: MAY 6 1921 Day: Year:

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6322 MARTIN LUTHER KING

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH

College (1-4 or 5+)

12TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business Industry

PRIVATE

17. Father's Name (First, Middle, Last)

FUQUA LAZENBY

18. Mother's Name (First, Middle, Maiden Surname)

LILLIE WILKERSON

19a. Informant's Name/Relationship (Type, Print)

EUGENE L. SELDEN JR. /SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1000 BRIGHT SEAT ROAD #319 LANDOVER MARYLAND 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

2/10/2011

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

K. D. Hall

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME, INC.

7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PERIPHERAL VASCULAR DISEASE

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

c. END STAGE RENAL DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTIPLE DECUBITI

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 ☐

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John E. Jones M.D.

29c. License number

D37142

29d. Date signed (Month, Day, Year)

2-3-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN E. JONES M.D. 2020 K STREET N.W. WASHINGTON DC 20006

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

John E. Jones M.D.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05702

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Genevieve Schoch

2. Date of Death

Month Day Year  
February 4, 2011

3. Time of Death

9:00 pM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Collington Assisted Living

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

5. Social Security Number

562-24-5913

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
September 27, 1922

9. Birthplace (State or Foreign Country)

Tujunga, CA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10450 Lottsford Vista Road, #415

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assistant Librarian

16b. Kind of Business Industry

Public Library

17. Father's Name (First, Middle, Last)

John Dillon

18. Mother's Name (First, Middle, Maiden Surname)

Helen Doe

19a. Informant's Name/Relationship (Type, Print)

Robert A. Schoch, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Ballantrae Drive, Elkton, MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

02/24/2011

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

4739 Baltimore Avenue  
Gasch's Funeral Home, P.A. Hyattsville, MD 2078123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death  
2 weeks

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47703

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. Duboyse, M.D., 12158 Central Avenue, Mitchellville, MD 20721

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05703

1 - For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALEXANDER LEROY SAUNDERS SR.</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>6</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>4A</b> M  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>DOCTORS HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>LANHAM</b>   |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |  |
| 5. Social Security Number<br><b>220-12-5000</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 24 1914</b>   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>PRINCE GEORGE'S</b>                                      | 10c. City, Town or Location<br><b>BRENTWOOD</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4311 LAWRENCE STREET</b>  |  | 10f. Zip Code<br><b>20722</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>NAVY</b><br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)  |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>   |  | 16b. Kind of Business Industry<br><b>PRIVATE</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ARTHUR SAUNDERS</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY PARKER</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SAMUEL R. SAUNDERS/SON</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2140 ADELINE ROAD PRINCE FREDERICK, MARYLAND 20678</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD VETERANS CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>CHELTENHAM, MARYLAND</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>K. D. H-hall</b>   |  | 22. Name and Address of Facility<br><b>J.B. JENKINS FUNERAL HOME, INC.<br/>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b>  |  |   |  |  | Approximate Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |
| a. Due to (or as a consequence of):<br><b>Small bowel Obstruction</b>  |  |   |  |  |  |
| b. Due to (or as a consequence of):  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>1) Pneumonia 2) Bilateral Pulmonary Embolism<br/>3) Malnutrition 4) Cachexia<br/>5) Cardiomyopathy</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>   |  | 29c. License number<br><b>MDD 60611</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02/07/11</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Samuel Astaw, MD. 8118 Good Luck Rd., Lanham, MD. 20706</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permitted. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05704

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Cornelia Lee Silver</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>4</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>3:45 A M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Hospice of St. Mary's</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Callaway</b>   |  | 4c. County of Death<br><b>St. Mary's</b>   |  |
| 5. Social Security Number<br><b>215-26-3394</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 10 1927</b> | 9. Birthplace (State or Foreign Country)<br><b>DC</b>  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>California</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>44762 Locust Ridge Court Apt. B</b>   |  |   |  | 10f. Zip Code<br><b>20619</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business Industry<br><b>PG Public Schools</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas W. Smith</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hannah V. Little</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robbin Pizza / Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11906 Wonder Ct. Monrovia, Md 21770</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | Date<br><b>2/10/11</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, Md</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Debra Marcis</i>   |  |   |  | 22. Name and Address of Facility<br><b>Fort Lincoln Funeral Home<br/>3401 Bladensburg Rd. Brentwood, Md 20772</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>mitral &amp; aortic stenosis</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) |  | 23d. Date of delivery<br>Month Day Year   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice Home</b> |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Jennifer Schmidt DO</i>  |  |   |  | 29c. License number<br><b>U0055751</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-8-11</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Schmidt DO<br/>40900 Merchants Lane Suite 205 Leonardtown MD 20650</b>   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 2011</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

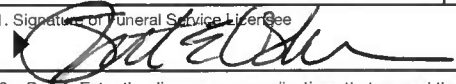
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05705

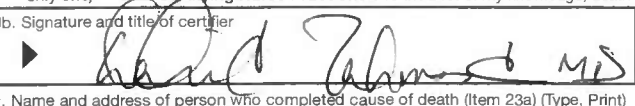

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Constance Eileen Stewart</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>10</b> , Year <b>2011</b>   |  | 3. Time of Death<br><b>8:10 p M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Williamsport Retirement Village</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>  |  | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>235-32-4136</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth<br>(Month, Day, Year) <b>April 14, 1926</b>                                       |  |
| 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |  | Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Williamsport</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>154 North Artizan Street</b>   |  |   |  | 10f. Zip Code<br><b>21795</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Teacher</b>   |  | 16b. Kind of Business Industry<br><b>Education</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George W. Bennett</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Ross</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joni Woodruff (Sister)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>196 Tecumseh Trail Hedgesville, WV 25427</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Assured Cremation Services</b>   |  | 20c. Date<br><b>2/14/2011</b>  |  | 20d. Location - City or Town, State<br><b>Parkersburg, WV</b>                                      |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Osborne Funeral Home P.A.<br/>425 S. Conococheague St Williamsport, MD 21795</b>  |  |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):  |  |  |  | Approximate Interval Between Onset and Death  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Advanced Dementia</b><br><b>Hypertension</b><br><b>Renal failure</b><br><b>Atrial fibrillation</b>  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of injury<br>M  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0063233</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02/11/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shahid Mahmood 580 C Northern Ave Hagerstown MD 21742</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>  |  | 32. Registrar's Signature<br>   |  |   |  |

State  
Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05706

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert Jackson Saum

2. Date of Death

February 7 2011

3. Time of Death

10:45 M

4a. Facility Name (if not institution, give street and number)

Meritus Regional Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

5. Social Security Number

212-24-5198

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

March 8, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington Co.

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17934 West Oak Ridge Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No 1945  
If Yes, Give Year or Dates. to 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business Industry

Truck Mfg.

17. Father's Name (First, Middle, Last)

Robert Kenneth Saum

18. Mother's Name (First, Middle, Maiden Surname)

Nora Belle Linebaugh

19a. Informant's Name/Relationship (Type, Print)

Ruth R. Saum/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17934 West Oak Ridge Drive, Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Beaver Creek Cemetery

Date

Feb. 11, 2011

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

Douglas A. Fiery

22. Name and Address of Facility Douglas A. Fiery Funeral Home

1331 Eastern Blvd. North, Hagerstown, MD 21742

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS  
Due to (or as a consequence of):b. MRSA BACTEREMIA  
Due to (or as a consequence of):c. PNEUMONIA  
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORD EXACERBATION, AFIB  
CKD, DM, DYSPHAGIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MONIQUE GOMA M.D.

29c. License number

D0065024

29d. Date signed (Month, Day, Year)

2/9/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONIQUE GOMA

11116 Medical Campus Road

Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

James A. Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05707

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Victoria Mary Schwenk

2. Date of Death  
Month Day Year

02/07/2011

3. Time of Death

2:13 pM

4a. Facility Name (If not institution, give street and number)

Mandrin Hospice House

4b. City, Town, or Location of Death

Harwood

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

215-44-2869

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

8. Date of Birth (Month, Day, Year)

01/10/1945

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Dunkirk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6355 Meadowland Drive

10f. Zip Code

20754

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jim Libert

18. Mother's Name (First, Middle, Maiden Surname)

Mary Fitzgerald

19a. Informant's Name/Relationship (Type, Print)

Robert Schwenk/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6355 Meadowland Drive, Dunkirk, MD 20754

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

02/10/2011

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Lisa M. Mounts

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.  
8125 Southern Md Blvd., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

CANCER OF PANCREAS

Approximate Interval Between Onset and Death

4 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

MANDRIN HOSPICE

HOUSE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter R. Graze, M.D.

29c. License number

D16364

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Graze, M.D. Wayson Pavilion, 2003 Medical Parkway, Suite 210, Annapolis, MD

31. Date filed (Month, Day, Year)

FEB - 9 2011

32. Registrar's Signature

Lenna S. Spaw

Baltimore, Maryland 21215-0036

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05708

1- For  
State  
Registrar

|  |   |   |   |  |  |   |  |  |
|--|---|---|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Helen B. Short</b>   |   |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>31</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>11:29 p M</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Calvert Memorial Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |   | 4c. County of Death<br><b>Calvert</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-03-6268</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>June 6, 1922</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Calvert</b>  |   | 10c. City, Town or Location<br><b>Sunderland</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>135 C. Jones Road</b>  |  | 10f. Zip Code<br><b>20689</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Second (0-12) <b>11</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Factory Worker</b>                    |  | 16b. Kind of Business Industry<br><b>Food</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Joynes</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beulah Maddox</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn T. Jones - daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>135 C. Jones Road, Sunderland, MD 20689</b>  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Samuel Wesley UM Church</b>  |  | Date<br><b>February 11, 2011</b>   |   | 20c. Location - City or Town, State<br><b>Manokin, MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Bladys A. Sewell</b>  |   |   |  | 22. Name and Address of Facility<br><b>Sewell Funeral Home, P.A.<br/>1451 Dares Beach Rd., Prince Frederick, MD 20678</b>  |   |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>MINUTES</b><br><b>YEARS</b> |   |   |  |  |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |   |   |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PREVIOUS STROKE, SEIZURE DISORDER</b>  |   |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred  |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>John H. Weiger</b>   |   |   |   | 29c. License number<br><b>D26358</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>FEB. 2 2011</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN H. WEIGER, MD - PRINCE FREDERICK, MD 20678</b>   |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB - 8 2011</b>   |   |   |   | 32. Registrar's Signature<br><b>Anna B. Spaw</b>                                       |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

JRW 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05709

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Louise M Sweitzer

2. Date of Death

Feb 12 2011

3. Time of Death

12:30 a<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

3508 Broadford Rd

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

216 80 8374

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 13, 1925

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3508 Broadford Rd

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Benjamin Shaffer

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Barrick

19a. Informant's Name/Relationship (Type, Print)

David Sweitzer son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3508 Broadford Rd. Oakland, MD 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Deer Park Cemetery

Date

2-14-11

20c. Location - City or Town, State

Deer Park, MD

21. Signature of Funeral Service Licensee

David A. Burdock

22. Name and Address of Facility

David A. Burdock FH P.A.

21 N 2nd St Oakland, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

b. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

c. Diabetes mellitus Type II

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 months

4 yrs

30 yrs

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald Richter MD

29c. License number

D30035

29d. Date signed (Month, Day, Year)

02/12/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald Richter MD 1027 MEMORIAL DRIVE OAKLAND MD 21550

31. Date filed (Month, Day, Year)

FEB 15 2011

32. Registrar's Signature

Antonia B. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur F. Shires

2. Date of Death

January 27, 2011

3. Time of Death

7:43pm M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

1806 Reynolds Court

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

204-36-4224

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

Sept. 20, 1946

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1806 Reynolds Ct.

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. 1968-95

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Captain

16b. Kind of Business Industry

Coast Guard

17. Father's Name (First, Middle, Last)

Peter Shires

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Grubic

19a. Informant's Name/Relationship (Type, Print)

Lana M. Shires / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 Reynolds Ct., Crofton, MD 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat'l Cem.

Date

2/23/11

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Beall Funeral Home  
6512 NW Crain Hwy. Bowie MD. 20715Physician/  
Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Renal cell carcinoma

Approximate Interval Between Onset and Death  
3 months

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

Bd 1084805

29d. Date signed (Month, Day, Year)

01/28/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew S. Dobin M.D. 4175 N. Hanson Ct 203 A Bowie MD 20716

31. Date filed (Month, Day, Year)

JAN 31 2011

32. Registrar's Signature

Annex B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For AMEND#23a per PHY State of Maryland / Department of Health and Mental Hygiene 2011 05711  
 State Registrar 2/8/2011 AACO HEALTH DEPT. CMH Certificate of Death Reg. No.

Physician/  
Medical  
Examiner

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Glen S Sippl</b>   |  |   |  | 2. Date of Death<br>Month <b>02</b> Day <b>01</b> Year <b>11</b>  |  | 3. Time of Death<br><b>10:20 PM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Baltimore Washington Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>390-40-0350</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 11, 1935</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Michigan</b>   |  | Usual Residence of Decedent   |  |   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Arnold</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>842 Meadow Heights Lane</b>  |  |   |  | 10f. Zip Code<br><b>21012</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br><b>1961-1963</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Fleet Manager</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fleet Manager</b>   |  | 16b. Kind of Business Industry<br><b>United Parcel Service</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph William Sippl</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dolores Shallow</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret M. Sippl / Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>842 Meadow Heights Lane Arnold, MD 21012</b>  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>   |  | Date<br><b>February 07, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Crownsville, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Ritchie Hwy, Severna Park, MD 21146</b>  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Non-ST Elevation Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Pulmonary fibrosis</b><br>Due to (or as a consequence of):<br>c. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DQA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |  |   |  | 29c. License number<br><b>071488</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/11/11</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Neda Motameni 301 Hospital Drive Glen Burnie, MD 21061</b>   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 2011</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |

Funeral  
Director

To Be Completed by Funeral Director

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05712

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Daryl M. Simms

2. Date of Death

February 2 2011

3. Time of Death

0915 M

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-60-9361

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 13 1954

9. Birthplace (State or Foreign Country)

D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

911 E. Royal St.

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Groundsman

16b. Kind of Business Industry

Bywater

Mutual Homes

17. Father's Name (First, Middle, Last)

Sherman Simms Jr

18. Mother's Name (First, Middle, Maiden Surname)

Matilda Brown

19a. Informant's Name/Relationship (Type, Print)

Litia Simms (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 Aster Dr. Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

2-7-11

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Ferry B. Reese MDC 483

22. Name and Address of Facility

Wm. Reese &amp; Sons Mortuary, P.A.

821 West St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)g ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daryl M. Simms

29c. License number

D0038445

29d. Date signed (Month, Day, Year)

02/02/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Litia Simms 2000 Medical Parkway, Annapolis, MD

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Daryl M. Simms

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05713

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

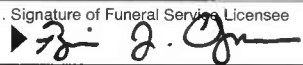
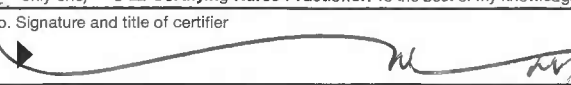
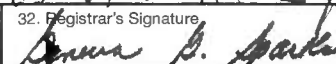
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Max Snyder</b>  |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>2,</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>2:44 P M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>858 Boatswain Way</b>   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| 5. Social Security Number<br><b>212-28-2350</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>79</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>8/31/1931</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |
| Usual Residence of Decedent  |  |  |   |   |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>858 Boatswain Way</b>   |  | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>1952-1954</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manufacturer Rep</b>  |  |
| 16b. Kind of Business Industry<br><b>Pipe Fittings</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Ben Snyder</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lilly Schockett</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Snyder Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>858 Boatswain Way Annapolis, MD 21401</b>  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hillcrest Memorial</b>  |   | 20c. Date<br><b>2/5/2011</b>  |  |
| 20d. Location - City or Town, State<br><b>Annapolis, MD</b>  |  | 21. Signature of Funeral Service Licensee<br>   |   |   |  |
| 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PARKINSONS DISEASE</b>   |   |   |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list condition/s, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)  |   | 23d. Date of delivery<br>Month Day Year   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |
| 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>DST2275</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 3, 2011</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL FREEDMAN 116 DEFENSE Highway Annapolis, MD 21401</b>  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 04 2011</b>  |  | 32. Registrar's Signature<br>   |   |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05714

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Sabo

2. Date of Death  
Month 1/31/2011 Day Year3. Time of Death  
1226 am

4a. Facility Name (if not institution, give street and number)

Genesis Spa Creek

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

013-01-4459

6. Sex

1 ☐ M ☒ F

7. Age (in yrs. last birthday)

92 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min. 6/2/1918

9. Birthplace (State or Foreign Country)

MA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

35 Milkshake Lane

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

US Government

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business Industry

Retail

17. Father's Name (First, Middle, Last)

Nicholas Rogowska

18. Mother's Name (First, Middle, Maiden Surname)

Anna Kuz

19a. Informant's Name/Relationship (Type, Print)

Kathleen Engler / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1064 Sun Valley Dr. Annapolis, MD 21409

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodbine Cemetery

Date

2/5/2011

20c. Location - City or Town, State

Oceanport, NJ

21. Signature of Funeral Service Licensee

▶ *[Signature]*

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1

2

3

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *[Signature]*

29c. License number

D32136

29d. Date signed (Month, Day, Year)

1/31/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gay J. Spivey 2100 D. Lowh Drive Charter, MD 21619

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

▶ *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05715

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie Mae Smith

2. Date of Death

Month Day Year  
02 02 2011

3. Time of Death

2:35 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Vindobona Nursing Home

4b. City, Town, or Location of Death

Braddock Hgts.

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

212-62-3579

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/21/1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7308 Old Middletown Rd.

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

Jasper Newton Gilbert

18. Mother's Name (First, Middle, Maiden Surname)

Dessie Mae Summers

19a. Informant's Name/Relationship (Type, Print)

Betty Wachter (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6934 Roy shafer Rd., Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lutheran cemetery

Date

2/5/2011

20c. Location - City or Town, State

Middletown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home

POB 18, Middletown, MD 21769

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Complete Heart Block

Approximate Interval Between Onset and Death

2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Yes 4 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20488

29d. Date signed (Month, Day, Year)

2/4/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James L. Roesster MD PO Box 20 MIDDLETOWN, MD 21769

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 25716

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Raymond Smith

2. Date of Death

January 29 2011 5:05 P M

3. Time of Death

4a. Facility Name (if not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

581-72-0488

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

8. Date of Birth (Month, Day, Year)

March 2, 1933

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

103 N. Edgewood Drive

10f. Zip Code

21740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. 1947-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Automobile Upholsterer

16b. Kind of Business Industry

Automobile

Upholstery

17. Father's Name (First, Middle, Last) (unk.)

18. Mother's Name (First, Middle, Maiden Surname) (unk.)

19a. Informant's Name/Relationship (Type, Print)

Goldie M. Smith / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 N. Edgewood Dr., Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gardens

Date

Feb. 2, 2011

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Resthaven Funeral Services, Skkot Cody P.A.

9501 Catocin Mountain Hwy. Frederick, MD 21701

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE LIVER DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE - UNCONTROLLED DM  
CAD - AFIBRILLATION - COPD - RA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONIQUE GONZA 11116 medical Campus Rd. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

James S. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05717

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leola Annette Scott

2. Date of Death

January 27, 2011

3. Time of Death

1:21 pM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

578-74-2073

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 9, 1948

9. Birthplace (State or Foreign Country)

District of Columbia

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Capital Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1929 Brooks Dr., Apt.# 303

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Emergency Registration Clerk

16b. Kind of Business Industry

Healthcare

17. Father's Name (First, Middle, Last)

James W. Oxley

18. Mother's Name (First, Middle, Maiden Surname)

Annette Ewell

19a. Informant's Name/Relationship (Type, Print)

Enga Tibbs-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1929 Brooks Dr., Apt.#303, Capitol Hghts, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Pk Crematory

Date

2-4-2011

20c. Location - City or Town, State

Riverdale, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bonnette &amp; Assoc. Funeral Home 2504 28th St., N.E., WDC 20018

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage congestive HEART Failure

Due to (or as a consequence of):

b. HYPERTENSIVE

Due to (or as a consequence of):

c. TYPE II Diabetes

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Mukemil Abdella, MD

29c. License number

D0059981

29d. Date signed (Month, Day, Year)

1/28/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukemil Abdella, MD. 3001 Hospital Dr. Cheverly, MD 20785

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05718

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jane Grace Salisbury

2. Date of Death

February 4 2011

3. Time of Death

7:00 a. M

4a. Facility Name (if not institution, give street and number)

Chesapeake Woods Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

070-34-7695

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

Feb. 10, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

525 Glenburn Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

Ben Gooden Butler

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Leota Typhair

19a. Informant's Name/Relationship (Type, Print)

Joyce Ann Baker

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27A Marston St., Apt. 111, Lewiston, ME 04240

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva

Date

2/8/11

20c. Location - City or Town, State

Delmar, DE

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Thomas Funeral Home P.A.

700 Locust St., Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death  
20 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension, diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H0059973

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Johnson 140 Bramble St, Cambridge, MD

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

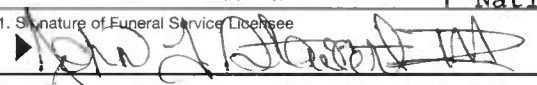
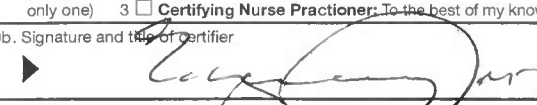
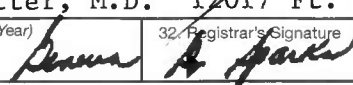
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05719

1- For  
State  
Registrar

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marie Lenora Tyler</b>  |   | 2. Date of Death<br>Month Day Year<br><b>February 6, 2011</b>  |  | 3. Time of Death<br><b>6:30 A<sup>M</sup></b>  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Fort Washington Nursing Home</b>  |   | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-38-8492</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>March 8, 1933</b>  | 9. Birthplace (State or Foreign Country)<br><b>DC</b>  |
|   | Usual Residence of Decedent  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>DC</b>  | 10b. County   | 10c. City, Town or Location<br><b>Washington</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>1607 Fort Davis Street SE</b>   |   | 10f. Zip Code<br><b>20020</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                          |  | 16b. Kind of Business Industry<br><b>Government</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Albert Logan</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Prescilla Poindexter</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gerald Tyler - Son</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1607 Fort Davis Street SE Washington, DC 20020</b> |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Stewart Funeral Home, Inc.<br/>4001 Benning Road NE Washington, DC 20019</b>                                    |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br>b. <b>Chronic Kidney Disease</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Decubitus Ulcer</b><br><b>Anemia</b>   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D42955</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 9, 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Edger V. Potter, M.D. 12017 Ft. Washington Rd. Ft. Washington, Md. 20744</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05721

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annie Cicilia Torboli

2. Date of Death

February 7, 2011

3. Time of Death

8:00 PM

4a. Facility Name (if not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

579-09-1472

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

8. Date of Birth (Month, Day, Year)

May 7, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8507 Mapleville Road

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Antinio DiVincenzo

18. Mother's Name (First, Middle, Maiden Surname)

Maria Buccone

19a. Informant's Name/Relationship (Type, Print)

Aldo S. Torboli, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Post Office Box 97 Halltown, West Virginia 25423

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Boonsboro Cemetery

Date

02/12/2011

20c. Location - City or Town, State

Boonsboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bast-Stauffer Funeral Home, PA  
7606 Old National Pike Boonsboro, MD 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1w

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

2.5x

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

052323

29d. Date signed (Month, Day, Year)

02-09-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muhammad Waseem, M.D. 1126 Opal Court Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

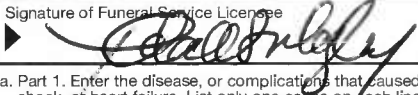
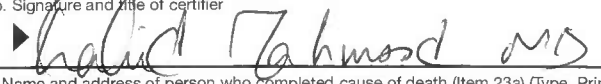

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05722

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mildred Cora Thomas</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>2:15 a M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Williamsport Retirement Village</b>  |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>   |  | 4c. County of Death<br><b>Washington</b>  |  |
| 5. Social Security Number<br><b>178-16-6843</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>May 30, 1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Williamsport</b>  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>154 North Artizan Street</b>   |  | 10f. Zip Code<br><b>21795</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business Industry<br><b>Own Home</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Victor Cleveland Provvard</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Liti Alice Bingaman</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Darlene K. Snyder / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14129 Cearfoss Pike Hagerstown, Maryland 21740</b>  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Broadfording Cem.</b>  |  | 20c. Location - City or Town, State<br><b>02/11/2011 Hagerstown, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Bast-Stauffer Funeral Home, PA<br/>7606 Old National Pike Boonsboro, MD 21713</b>  |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>a. Due to (or as a consequence of):<br><b>Dysphagia</b><br>b. Due to (or as a consequence of):<br><b>Vascular Dementia</b><br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |   |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary artery disease, Hypertensive heart disease</b>  |  |   |  |   |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |  | 23d. Date of delivery<br>Month <b>02</b> Day <b>08</b> Year <b>2011</b>   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br><b>02/08/2011</b>   |  | 28b. Time of injury<br><b>M</b>   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 29b. Signature and Title of certifier<br>  |  | 29c. License number<br><b>D0063233</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02/08/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>580 Northern Ave Hagerstown MD 21742</b>   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |  | 32. Registrar's Signature<br>  |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mona Thatcher

2. Date of Death

Month Day Year  
02 07 2011

3. Time of Death

3:45pm

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Julia Manor Health Care Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

297-34-8223

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 29 1938

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

55 E. Washington Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Her own home

17. Father's Name (First, Middle, Last)

Lester L. Birkheimer

18. Mother's Name (First, Middle, Maiden Surname)

Effie Canfield

19a. Informant's Name/Relationship (Type, Print)

David L. Thatcher - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

55 E. Washington Street, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

2/8/2011

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Munnich

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Metastatic Breast Cancer

Due to (or as a consequence of):

b. Bone Metastasis

Due to (or as a consequence of):

c. Pancreatic Carcinoma

Due to (or as a consequence of):

d. Coronary Artery Disease

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Encephalopathy, Dysphagia, Malnutrition  
Cerebral Vascular Accident, Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Barbara Naden-Blucher CRNP

29c. License number

R125360

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Naden-Blucher, 333 Mill Street, Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Annun B. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05724

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Virginia Teets

2. Date of Death

Month Day Year  
Feb. 4, 2011

3. Time of Death

12:20 P M

4a. Facility Name (If not institution, give street and number)

Oakland Nursing &amp; Rehab. Center

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

235-30-3540

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
5/28/1923

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Preston

10c. City, Town or Location

Terra Alta

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

209 Alpine Lake RD.

10f. Zip Code

26764

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business Industry

US Postal Service

17. Father's Name (First, Middle, Last)

George

Vance

18. Mother's Name (First, Middle, Maiden Surname)

Alice

Cowger

19a. Informant's Name/Relationship (Type, Print)

Robin Davis/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

209 Alpine Lake RD., Terra Alta, WV 26764

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Aurora Cemetery

Date

2/7/2011

20c. Location - City or Town, State

Aurora, WV

21. Signature of Funeral Service Licensee

Richard L. Mettrey

22. Name and Address of Facility

Newman Funeral Homes P.A.

203 S. Second St., Oakland, MD 21550

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):  
Severe Alzheimer's Dementia

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas Johnson

29c. License number

D15333

29d. Date signed (Month, Day, Year)

2/11/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Thomas Johnson 311 N. Fourth St., Oakland, MD 21550

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Richard L. Mettrey

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #7,8,18 Per FH State of Maryland / Department of Health and Mental Hygiene  
 1- For State Registrar 2/14/2011 ACO HEALTH DEPT CMH Certificate of Death Reg. No. 2011 05725

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Charlotte E. Thomas  
 2. Date of Death Month Day Year January 30 2011  
 3. Time of Death 6:00 PM

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Tate Hospice House  
 4b. City, Town, or Location of Death Linthicum  
 4c. County of Death Anne Arundel  
 5. Social Security Number 217-58-0995  
 6. Sex 1 ☐ M 2 ☒ F  
 7. Age (In yrs. last birthday) 56 57 Yrs.  
 8. Date of Birth 11/6/54  
 9. Birthplace (State or Foreign) Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent  
 10a. State Maryland  
 10b. County Anne Arundel  
 10c. City, Town or Location Glen Burnie  
 10d. Inside City Limits 1 ☐ Yes 2 ☒ No  
 10e. Street and Number 309 Scott Avenue  
 10f. Zip Code 21060  
 10g. Citizen of What Country? USA  
 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  
 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.  
 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
 14. Race - American Indian, Black, White, etc. Specify: Black  
 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 6yrs  
 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical  
 16b. Kind of Business Industry Anne Arundel Medical Center  
 17. Father's Name (First, Middle, Last) William E. Gilreath Sr.  
 18. Mother's Name (First, Middle, Maiden Surname) Gladys Geneva East ~~Carrie B. McCurdy~~  
 19a. Informant's Name/Relationship (Type, Print) (Brother) William E. Gilreath Jr.  
 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Scott Avenue Glen Burnie, Md. 21060  
 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
 20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Memorial Park  
 20c. Location - City or Town, State 2/5/11 Laurel, Md.  
 21. Signature of Funeral Service Licensee [Signature] Wm. Reese & Sons Mortuary, P. A.  
 821 West St. Annapolis, Md. 21401

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
 Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma multiforme  
 Due to (or as a consequence of):  
 b. Due to (or as a consequence of):  
 c. Due to (or as a consequence of):  
 d. Due to (or as a consequence of):  
 IF FEMALE:  
 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 3 ☐ Unknown  
 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) g ☐ Unknown  
 23d. Date of delivery Month Day Year

To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown  
 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No  
 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice house  
 27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined  
 28a. Date of injury (Month, Day, Year)  
 28b. Time of injury M  
 28c. Injury at work? 1 ☐ Yes 2 ☐ No  
 28d. Describe how injury occurred  
 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
 28f. Location (Street and Number or Rural Route Number, City or Town, State)  
 29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 29b. Signature and title of certifier [Signature] 29c. License number D39505 29d. Date signed (Month, Day, Year) February 7, 2011  
 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Markam 305 Hospital Dr, Glen Burnie, MD. 21061  
 31. Date filed (Month, Day, Year) FEB 08 2011 32. Registrar's Signature [Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05726

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MAZIE ELIZABETH TREGONING</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>3</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>5:57 A M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>  |  |
| 5. Social Security Number<br><b>219-14-9286</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 14, 1923</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Thurmont</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6327 Mountaindale Road</b>  |  | 10f. Zip Code<br><b>21788</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Presser</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Presser</b>   |  | 16b. Kind of Business Industry<br><b>Sewing Company</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Watkins</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Blentinger</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Tregoning / Grandson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>841 Insley Circle, Frederick, MD 21701</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven</b>  |  | Date<br><b>2/7/2011</b>  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>                                  |  |
| 21. Signature of Funeral Service Licensee<br><b>Louise Stauffer</b>  |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Home</b><br><b>1621 Opossumtown Pike, Frederick, MD 21702</b>   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>ANTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>MULTIPLE MYELOMA</b>                          |  |   |  | Approximate Interval Between Onset and Death<br><b>6 hrs</b><br><b>10 yrs</b>  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTIPLE MYELOMA</b>  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D-31912</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/3/2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Julio Menocal M.D., 110 Baughmans Lane, Frederick, MD 21702</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 07 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05727

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Delores Thornton

2. Date of Death

January 31, 2011

3. Time of Death

12:40 P M

4a. Facility Name (if not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-38-5723

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 10, 1933

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 57th Street SE #B

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physical Therapist

16b. Kind of Business Industry

Private

17. Father's Name (First, Middle, Last)

Frank Carter

18. Mother's Name (First, Middle, Maiden Surname)

Helen Tolson

19a. Informant's Name/Relationship (Type, Print)

Deborah Thornton - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 57th Street SE #B Washington, DC 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony

Date

February 9, 2011

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

John A. Stewart

22. Name and Address of Facility

Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Encephalopathy

Due to (or as a consequence of):

b. Cardiac Arrest

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Yes 4 ☐ No5 ☐ Yes 6 ☐ No7 ☐ Yes 8 ☐ No9 ☐ Yes 10 ☐ No

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

End Stage Renal Disease

Peripheral Vascular Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan Duran, M.D.

29c. License number

D66249

29d. Date signed (Month, Day, Year)

01, 31, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Duran, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

FEB 04 2011

32. Registrar's Signature

Jonathan D. Duran

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05728

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Alvin Wright

2. Date of Death

Month 2 Day 6 Year 2011 10:27 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

5. Social Security Number

228-14-1357

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

APRIL 16 1925

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1228 LINDEN PLACE N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 YR

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DENTAL TECH

16b. Kind of Business Industry

FED. GOVERNMENT

17. Father's Name (First, Middle, Last)

ALVIN NELSON WRIGHT SR.

18. Mother's Name (First, Middle, Maiden Surname)

PERNOLA JEFFRIES

19a. Informant's Name/Relationship (Type, Print)

DELOIS P. WRIGHT/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1228 LINDEN PLACE N.E. WASHINGTON, DC 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FT. LINCOLN CEMETERY

Date

2/12/2011

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

K. S. M. Hall

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME, INC.

7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Acute Coronary Syndrome

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Erin Smith, MD

29c. License number

D066082

29d. Date signed (Month, Day, Year)

2/16/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Erin Smith 7600 Carroll Ave Takoma Park, MD

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Benjamin S. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DIANA DOUGLAS WHITE

2. Date of Death

FEBRUARY 6 2011

3. Time of Death

2:55 A M

4a. Facility Name (if not institution, give street and number)

NATIONAL INSTITUTES OF HEALTH

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

374-56-0053

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 9, 1951

9. Birthplace (State or Foreign)

Michigan

Usual Residence of Decedent

10a. State

VA

10b. County

Fairfax

10c. City, Town or Location

Alexandria

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2405 Daphne Lane

10f. Zip Code

22306

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Staffer

16b. Kind of Business Industry

US Congress

17. Father's Name (First, Middle, Last)

John Douglas

18. Mother's Name (First, Middle, Maiden Surname)

Paula Gaw

19a. Informant's Name/Relationship (Type, Print)

Patrick White

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2405 Daphne Lane Alexandria VA 22306

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Everly Crematory

Date

2/9/2011

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Everly-Wheatley F.H.

1500 W. Braddock Road Alexandria VA 22302

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hepatorenal syndrome

Due to (or as a consequence of):

b. cholangio carcinoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
14 days

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pulmonary embolism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

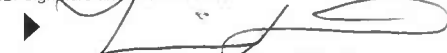
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

256907

29d. Date signed (Month, Day, Year)

February 6, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDY L. DAVIS

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05730

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EUGENE WATSON

2. Date of Death

Month Day Year  
FEBRUARY 8 2011

3. Time of Death

08:32 AM

4a. Facility Name (if not institution, give street and number)

UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

428-56-2016

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

75

8. Date of Birth (Month, Day, Year)

Apr. 5, 1935

9. Birthplace (State or Foreign Country)

MS

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9701 Viers Drive

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business Industry

Transportation

17. Father's Name (First, Middle, Last)

Herbert Witherspoon

18. Mother's Name (First, Middle, Maiden Surname)

Mariah Thomas

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Ogburn - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1201 Kings Heather Dr., Bowie, MD 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Park Cemetery

Date

2/14/2011

20c. Location - City or Town, State

Poplarville, MS

21. Signature of Funeral Service Licensee

Judith K. Johnson

22. Name and Address of Facility

J. K. Johnson Funeral Home P. A.  
6503 Old Branch Ave., Temple Hills, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AORTIC STENOSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Chronic Kidney Disease

Subdural Hematoma

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

PZ3080

29d. Date signed (Month, Day, Year)

FEBRUARY 8, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timothy Phelan, MD 22 S. Greene St., Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

Diana S. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05731

1- For State Registrar

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
Frederick Albert Williams, Jr.2. Date of Death  
Month Day Year  
01/15/20113. Time of Death  
0230 AMFuneral  
Director4a. Facility Name (If not institution, give street and number)  
1107 Revolution Street4b. City, Town, or Location of Death  
Havre de Grace4c. County of Death  
Harford5. Social Security Number  
216-12-55956. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
85 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month Day Year)  
06-17-19259. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Harford10c. City, Town or Location  
Havre de Grace10d. Inside City Limits  
1 ☒ Yes 2 ☐ No10e. Street and Number  
1107 Revolution Street10f. Zip Code  
2107810g. Citizen of What Country?  
United States of America11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
1216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Machinist16b. Kind of Business/Industry  
Civil Service17. Father's Name (First, Middle, Last)  
Frederick A. Williams, Sr.18. Mother's Name (First, Middle, Maiden Surname)  
Theresa Roxanne Palmer19a. Informant's Name/Relationship (Type, Print)  
Patricia W. Perrone (daughter)19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
318 Brady Lane, Middletown, Delaware 1970920a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Angel Hill CemeteryDate  
01/21/201120c. Location - City or Town, State  
Havre de Grace, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Zellman Funeral Home, P.A. 21078  
123 South Washington St, Havre de Grace, Maryland23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Liver Cancer.

Due to (or as a consequence of):

b. prostate Cancer

Due to (or as a consequence of):

c. Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J T Lee M.D. 669 Revolution St. Havre de Grace, MD. 21078

31. Date filed (Month, Day, Year)  
FEB 11 2011

32. Registrar's Signature

A. B. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Reg. No. \_\_\_\_\_

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05733

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Pearl Williams</b>  |  | 2. Date of Death<br>Month: <b>2</b> Day: <b>5</b> Year: <b>2011</b>   |   | 3. Time of Death<br><b>2:30 M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>298-36-5980</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Apr 23 1937</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |   |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Annapolis</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3500 Rockway Ave</b>   |   | 10f. Zip Code<br><b>21403</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>4yrs</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Educator</b>  |   | 16b. Kind of Business/Industry<br><b>Anne Arundel Co. Board of Education</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John W. Jackson</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pearlie M. DeJarnette</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Leon T. Williams (Husband)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3500 Rockway Ave Annapolis, Md. 21403</b> |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Larry S. Reese MDC883</b>  |  | 22. Name and Address of Facility<br><b>Wm. Reese &amp; Sons Mortuary, P.A.<br/>821 West St. Annapolis, Md. 21401</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pancreatic cancer</b><br>Approximate Interval Between Onset and Death<br><b>16 months</b>   |  |   |   |  |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month: _____ Day: _____ Year: _____   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)    |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>J. M. Reese</b>  |  | 29c. License number<br><b>D0064379</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/7/2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jay Rhee 900 Bestgate Rd Suite 300 Annapolis, MD</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 2011</b>  |  | 32. Registrar's Signature<br><b>Denise S. Sparks</b>  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05734

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |   |   |   |  |
|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ruth Wade</b>   |   | 2. Date of Death<br>Month <b>February</b> Day <b>1</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>6:00 a</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>130 Hearne Road Apt. 507</b>  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |
| 5. Social Security Number<br><b>212-36-0870</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 23 1940</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent  |   |   |   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Anne Arundel</b>  | 10c. City, Town or Location<br><b>Annapolis</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>130 Hearne Rd. Apt 507</b>  |   | 10f. Zip Code<br><b>21401</b>   | 10g. Citizen of What Country?<br><b>USA</b>               |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cab Company Owner</b>   |   | 16b. Kind of Business Industry<br><b>Reliable Cab Co.</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Allen</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Norene Cromwell</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Louis Wade (Husband)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>130 Hearne Rd. Apt 507 Annapolis, Md. 21401</b>   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Burial Place (Name of cemetery, crematory or other place)<br><b>Memorial Park</b>  | Date<br><b>2-7-11</b>                                     | 20c. Location - City or Town, State<br><b>Annapolis, Md.</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Garry H. Reese M00483</b>  |   | Name and address of facility<br><b>Wm. Reese &amp; Sons Mortuary, P.A.<br/>821 West St. Annapolis, Md. 21401</b>  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>FAILURE TO THRIVE</b><br>Due to (or as a consequence of):<br>b. <b>PARKINSON'S DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   | Approximate Interval Between Onset and Death<br><b>4 MONTHS</b><br><b>10 YEARS</b>   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSIVE HEART DISEASE</b><br><b>HYPERLIPIDEMIA</b>   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M                                  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>Garry H. Reese F.O.</b>  |   | 29c. License number<br><b>H47494</b>  | 29d. Date signed (Month, Day, Year)<br><b>2/2/2011</b>    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Monique Y. Langston, DO 1616 Forest Dr. #1 Annapolis, md. 21403</b>   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 2011</b>  |   | 32. Registrar's Signature<br><b>Penina B. Spaw</b>  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For AMEND#100 per FH State of Maryland / Department of Health and Mental Hygiene  
 1- State Registrar 2/2/2011 ACCO HEALTH DEPT. CMH Certificate of Death

Reg. No. 2011 05735

Physician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |   |   |   |
|---|--|---|---|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>DIANA WILLIAMS</b>   |  |   | 2. Date of Death<br>Month <b>01</b> Day <b>31</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>0942</b> M                           |
| 4a. Facility Name (if not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>  |  |   | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS, MD</b>  |   | 4c. County of Death<br><b>ANNE ARUNDEL COUNTY</b>           |
| 5. Social Security Number<br><b>214-44-1135</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>01/03/45</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent   |  |   |   |   |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>ANNE ARUNDEL</b>   | 10c. City, Town or Location<br><b>ANNAPOLIS</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>1502 MASONETTA WAY</b>   |  | 10f. Zip Code<br><b>21409</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>                  |   |   |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Real Estate Appraiser</b>   |  | 16b. Kind of Business Industry<br><b>Real Estate</b>  |   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles F. Barney</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Pierson</b>  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Husband Frederick Albert Williams III</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1502 Masonetta Way, Annapolis, MD 21409</b> |   |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Crematory</b>   |   | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Michael T. Kleck</b>  |  | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home<br/>147 Duke of Gloucester St, Annapolis, MD 21401</b>                             |   |   |   |

To Be Completed by Funeral Director

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>MULTIPLE MYELOMA</b><br>Due to (or as a consequence of):<br><b>ESRD</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                                       |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                 |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>DR. RAVIN GARC</b><br><b>ONCOLOGY</b>  |  | 29c. License number<br><b>DO 064852</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>1/31/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAVIN GARC 2001 MEDICAL PARKWAY, ANNAPOLIS, MD 21401</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 02 2011</b>  |  | 32. Registrar's Signature<br><b>Anna B. Sparks</b>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

CH10

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05736

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Juanita Wroten

2. Date of Death

February 2 2011

3. Time of Death

1024 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

220-28-0412

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 18, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

211 Choptank Avenue

10f. Zip Code

21613

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Goley Wesley Insley

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Irene Willey

19a. Informant's Name/Relationship (Type, Print)

William M. Wroten Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 Choptank Avenue Cambridge, Maryland 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dor. Memorial Park

Date

2/5/11

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

Thomas Funeral Home, P.A.

21. Name and Address of Facility

700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hyperlipidemia, Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jois a Jan D.O.

29c. License number

H44615

29d. Date signed (Month, Day, Year)

2/4/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lois A. NARR D.O. 100 Brable St Cambridge MD

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Andrew P. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05737

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Ann Yeakle

2. Date of Death

February 10, 2011

3. Time of Death

0325 A M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-34-9467

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

2-5-1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Clear Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12409 Nesbitt Ave.

10f. Zip Code

21722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

co-owner/ secretary

16b. Kind of Business Industry

gas station/tow co.

17. Father's Name (First, Middle, Last)

Fred Sword

18. Mother's Name (First, Middle, Maiden Surname)

Etta May Repp

19a. Informant's Name/Relationship (Type, Print)

Donald F. Yeakle Sr. husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12409 Nesbitt Ave. Clear Spring, MD 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Paul Cem.

Date

2-14-2011

20c. Location - City or Town, State

Clear Spring, MD

21. Signature of Funeral Service Licensee

Daniel O. Pauley Jr. CFSP

22. Name and Address of Facility

Donald Edwin Thompson Funeral Home, Inc  
P.O. BOX 310 Clear Spring, MD 21722

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

26. Place of Death (Check only one)  
1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

00055994

29d. Date signed (Month, Day, Year)

2/10/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LISA Haggins Bottomam  
1110 MEDICAL CAMPUS DR #130 HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 19a, per INF 6913.3/4/2011, WS

State of Maryland / Department of Health and Mental Hygiene

2011 05738

1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

Funeral  
Director

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Minnie Avery</b>  |  |  |  | 2. Date of Death<br>Month <b>2</b> - Day <b>23</b> - Year <b>11</b>  |  | 3. Time of Death<br><b>6:00 a.m.</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Joseph Richey House</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>na</b>   |  |
| 5. Social Security Number<br><b>218-22-6534</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>9-1-1922</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b>  |  |
| Usual Residence of Decedent  |  |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>na</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>714 Edgewood Street</b>   |  |  |  | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>na</b> College (1-4 or 5+) <b>na</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>   |  | 16b. Kind of Business Industry<br><b>Private Homes</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Thomas</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Littlejohn</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Fortune Minnie Avery-Daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>714 Edgewood Street Baltimore, MD 21229</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Pk</b>  |  | 20c. Location - City or Town, State<br><b>3-2-2011 Randallstown, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>B. Clayton</b>   |  |  |  | 22. Name and Address of Facility<br><b>March East F/H 1101 E. North Avenue Balto, MD 21202</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>End stage renal disease</b>   |  |  |  |  |  |  |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>W. B. Brown</b>  |  |  |  | 29c. License number<br><b>H0064267</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-23-11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Karen Brown-Brown 827 Linden Av Balto, MD 21201</b>   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |  |  | 32. Registrar's Signature<br><b>James A. Parker</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

30

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05739

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Margaret Cecelia Arthur

2. Date of Death

Month Day Year  
February 16, 2011

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

1953 Haselmere Rd

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

215-22-3533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 21, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1953 Haselmere Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

0

16a. Decedent's Usual Occupation un  
(Give kind of work done during most of working  
life. DO NOT use retired)

16b. Kind of Business/Industry un

17. Father's Name (First, Middle, Last)

Thomas Michael Geary

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Vaeth

19a. Informant's Name/Relationship (Type, Print)

Darlene Arthur - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1953 Haselmere Rd; Baltimore, Maryland 21222

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility State Anatomy Board

655 W. Baltimore St; Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate  
Interval Between  
Onset and Death

25 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation  
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ronald S. Wade, M.D.

29c. License number

D33407

29d. Date signed (Month, Day, Year)

02/22/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

207 WISE AVENUE, DUNDALK, MD 21222

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Ronald S. Wade

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05740

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mina Cristeene Anderson

2. Date of Death

February 18, 2011

3. Time of Death

11:15 PM

4a. Facility Name (if not institution, give street and number)

Citizens Nursing Home

4b. City, Town, or Location of Death

Havre De Grace

4c. County of Death

Harford

5. Social Security Number

218-32-5936

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

8. Date of Birth

Feb. 26, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Churchville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39 Bramble Lane

10f. Zip Code

21028

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business Industry

Public Schools

17. Father's Name (First, Middle, Last)

Joseph Paul Fickus

18. Mother's Name (First, Middle, Maiden Surname)

Hulda (nmn) Hipkins

19a. Informant's Name/Relationship (Type, Print)

Stephen H. Anderson / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

511 Camilla St., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gdn.

2-24-11

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emery

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

chronic kidney disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

2/18/11

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. Simpson M.D.

29c. License number

P4641

29d. Date signed (Month, Day, Year)

2/21/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Simpson 251 W. 1st Ave MD 21028

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

B. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

permitted. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

05741

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Emperatriz

Adamski

2. Date of Death

February 22, 2011

3. Time of Death

12:02A M

4a. Facility Name (If not institution, give street and number)

12204 Gaynor Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

493-48-9334

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 20, 1917

9. Birthplace (State or Foreign Country)

Peru

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12204 Gaynor Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☒ Yes 2 ☐ No Specify: Peruvian

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Tomas Cayatopa

18. Mother's Name (First, Middle, Maiden Surname)

Robertina Davila

19a. Informant's Name/Relationship (Type, Print)

Alberto Linares / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12204 Gaynor Road Rockville, Maryland 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

February 26,

Gate of Heaven Cemetery 2011

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

MO1607

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home Rockville, Inc.  
300 W. Montgomery Avenue Rockville, Maryland 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Respiratory Failure

b. Due to (or as a consequence of):

LUNG CANCER

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 wk

1 yr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

autopsy  
performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DGA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

MD 56065

29d. Date signed (Month, Day, Year)

2/22/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carlos E. Picone, M.D. 5530 Wisconsin Avenue #930 Chevy Chase, Maryland 20815-4316

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05742

1 - For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |                                       |  |  |  |   |  |   |   |
|--|---|--|---|---------------------------------------|--|--|--|---|--|---|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARIE ABBOTT</b>   |  |   |                                       | 2. Date of Death<br>Month <b>February</b> Day <b>19</b> Year <b>2011</b>   |  |  |   | 3. Time of Death<br><b>3:40 P M</b>  |   |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Elizabeth Rehabilitation &amp; Nursing Center</b>  |  |   |                                       | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |  |   | 4c. County of Death<br><b>N/A</b>  |   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-05-0051</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 22, 1912</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |
|  | Usual Residence of Decedent   |  |   |                                       |  |  |  |   |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |                                       | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |
|  | 10e. Street and Number<br><b>1821 Westphal Place</b>  |  |   |                                       | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                  |   |  |   |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |   |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business Industry<br><b>Housewife &amp; Mother</b>         |  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>William G. Croney</b>   |  |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha E. Getner</b>   |  |  |   |  |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan M. McGonigal (Daughter)</b>   |  |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1500 Covington Street, Baltimore, Maryland 21230</b>   |  |  |   |  |   |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>   |  | Date<br><b>2/23/2011</b>                                     |   | 20c. Location - City or Town, State<br><b>Elkridge, Maryland</b>                                   |   |   |
|  | 21. Signature of Funeral Service Licensee <b>Kevin E Ecker</b>  |  |   |                                       | 22. Name and Address of Facility <b>McCully-Polyniak Funeral Home, P.A.</b><br><b>130 East Fort Avenue, Baltimore, Maryland 21230</b>  |  |  |   |  |   |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>pneumonia</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension</b> |  |   |                                       |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |   |                                       |  |  |  |   |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hiatal hernia</b>   |   |  |   |                                       |  |  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                       |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                       |  |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)                                       |   | 28b. Time of injury<br><b>M</b>       |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                                       |  |  |  |   |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |                                       |  |  |  |   |  |   |   |
| 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br><b>055 391</b> |  | 29d. Date signed (Month, Day, Year)<br><b>February 21, 2011</b>                      |  |   |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ming Yi MD 3320 Benson Ave nue. Baltimore, Maryland 21227</b>   |   |  |   |                                       |  |  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |   |  |   | 32. Registrar's Signature<br>         |  |  |  |   |  |   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John F. Bailey

2. Date of Death

February 22 2011

3. Time of Death

2:40 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

220-18-2136

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
3/7/1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5311 Hamlin Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business Industry

Gordon Box Co.

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Bailey

19a. Informant's Name/Relationship (Type, Print) (Daughter)

Ms. Veronica McMorris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5311 Hamlin Ave. Balto., MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

3/3/2011

20c. Location - City or Town, State

Arbutus, MD

21. Signature of Funeral Service Licensee

Patelle G. Harris L.M.

22. Name and Address of Facility

Joseph L. Russ Funeral Home P.A.  
2225 W. North Ave. Balto., MD 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CardioPulmonary Arrest.

Due to (or as a consequence of):

b. Pulseless Electrical Activity

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d. Coronary Artery Disease and Hypertension

Approximate Interval Between Onset and Death

Physician/  
Medical  
Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Brandon Lebow

29c. License number

161929313

29d. Date signed (Month, Day, Year)

02/22/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brandon Lebow Union Memorial Hospital Department of Medicine 201F University Parkway MD 21218

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Kenna B. Spivey

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State  
Registrar

DHMH 17 Rev 7/2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 05744

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Biggus</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>23</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>1230 PM</b>   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Joseph Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-34-6238</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 27, 1937</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>5209 Midwood Ave</b>  |  |   |  | 10f. Zip Code<br><b>21212</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cashier</b>   |  | 16b. Kind of Business Industry<br><b>Staples</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Howard Goode Mosby</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Norma Mosby</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cassandra Garrett</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5403 Luthian Rd, Balto MD 21212</b>  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |  | Date<br><b>3-1-2011</b>  |  | 20c. Location - City or Town, State<br><b>Dwings Mills, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Don C. Howell</b>  |  |   |  | 22. Name and Address of Facility<br><b>Howell Funeral Home<br/>4600 Liberty Heights Ave, Balto MD 21207</b>  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Shock</b><br>Due to (or as a consequence of):<br>b. <b>Acute Respiratory Failure</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |  |  |  |  |
|  | Approximate Interval Between Onset and Death   |  |   |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|  | 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Status Post Cerebrovascular accident</b>  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>Neal Richard Frankel</b>   |  |   |  | 29c. License number<br><b>H58708</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 23, 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Neal Richard Frankel D.O. 7601 Osler Drive Towson, Md 21204</b> |  |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |   |  | 32. Registrar's Signature<br><b>Donna B. Davis</b>   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |                                |  |  |  |
|---|--|---|--------------------------------|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DORIS BORMUTH</b>  |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>18</b> Year <b>2011</b>  |                                | 3. Time of Death<br><b>9.20 A M</b>  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>3310 Benson Avenue Apt. 309</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                | 4c. County of Death<br><b>N/A</b>  |  |  |
| 5. Social Security Number<br><b>217 09 8600</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>12/07/1915</b>                       |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |                                |  |  |  |
| Usual Residence of Decedent   |  |   |                                |  |  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>3310 Benson Avenue Apt. 309</b>  |  | 10f. Zip Code<br><b>21227</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>   |                                | 16b. Kind of Business Industry<br><b>Baltimore City</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Louis Saylor</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Salisbury</b>   |                                |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Welsh / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1422 Rowe Drive Glen Burnie, Maryland 21061</b>   |                                |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Jerome Gronowicz</b>  |  | 22. Name and Address of Facility<br><b>Gonce Funeral Service, P.A.<br/>4001 Ritchie Highway Baltimore, Maryland 21225</b>   |                                |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><b>c. HYPOTHYROIDISM</b><br>Due to (or as a consequence of):<br><b>d. OSTEOPOROSIS.</b>   |  |   |                                |  | Approximate Interval Between Onset and Death<br><b>APPROXIMATELY TWO HOURS</b> |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |                                | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br><b>HYPOTHYROIDISM</b><br><b>OSTEOPOROSIS.</b>   |  |   |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M       | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |  |  |
| 29b. Signature and title of certifier<br><b>Komal Dang</b>  |  | 29c. License number<br><b>D0018362</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>2-18-2011</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Komal K. Dang MD. 3455 Wilkens Ave Ste 410, Balto. Md 21229</b>  |  |   |                                |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  | 32. Registrar's Signature<br><b>John B. Gave</b>  |                                |  |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05746

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|   |                                 |  |  |  |   |
|---|---------------------------------|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Richard Bowers</b>   |                                 | 2. Date of Death<br>Month: <b>02</b> Day: <b>19</b> Year: <b>2011</b>  |  | 3. Time of Death<br><b>1828 P M</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Upper Chesapeake Medical Center</b>  |                                 | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  | 4c. County of Death<br><b>Harford</b>  |   |
| 5. Social Security Number<br><b>218-90-7091</b>   | 6. Sex<br><b>1</b> M <b>2</b> F | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   | If Under 1 Year<br>Months: Days: Hours: Min.                                 | 8. Date of Birth (Month, Day, Year)<br><b>06-12-1962</b>   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
| Usual Residence of Decedent   |                                 |  |  |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Abingdon</b>   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> X No  |   |
| 10e. Street and Number<br><b>212 Lodgecliff Ct</b>  |                                 | 10f. Zip Code<br><b>21009</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> X Married<br><b>3</b> Widowed <b>4</b> Divorced   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> X No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> X No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>  |  |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Management</b>  |                                 | 16b. Kind of Business Industry<br><b>Food Service</b>  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles C. Bowers</b>   |                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shirley Boeshore</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Danielle Bowers (Wife)</b>   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>212 Lodgecliff Ct Abingdon, MD 21009</b>                                     |  |  |   |
| 20a. Method of Disposition<br><b>1</b> X Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highview Mem. Gardens</b>   |  | 20c. Location - City or Town, State<br><b>02-24-2011 Fallston, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |                                 | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014</b>  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Septic Shock</b><br>Severely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Severe pneumonia</b>  |                                 |  |  |  | Approximate Interval Between Onset and Death  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No <b>9</b> Unknown  |                                 |  |  |  | 23c. If yes, outcome of pregnancy<br><b>1</b> Live Birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown |
| 23d. Date of delivery<br>Month: Day: Year:  |                                 |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic renal failure</b><br><b>Coronary artery disease</b>  |                                 |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> X Unknown   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> X No  |                                 |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> X No   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> X No  |                                 | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DCA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |   |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |                                 | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M   | 28c. Injury at work?<br><b>1</b> Yes <b>2</b> No   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. Certifier (Check only one)<br><b>1</b> X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>3</b> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |  |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |                                 | 29c. License number<br><b>D63420</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 19, 2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sid Z. Kharal, 500 Upper Chesapeake Dr Bel Air MD 21014</b>  |                                 |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |                                 | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bowers, Charles Richard

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05747

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MIRIAM KATHERINE BRESCIA

2. Date of Death

Month FEB Day 20 Year 2011

3. Time of Death

05:20 A M

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

216-54-0317

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 17, 1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Fulton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8532 Edenton Road

10f. Zip Code

20759

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business Industry

Food Service

17. Father's Name (First, Middle, Last)

Donald J. Brescia

18. Mother's Name (First, Middle, Maiden Surname)

Rena Katherine Plum

19a. Informant's Name/Relationship (Type, Print)

Richard Carter/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8532 Edenton Road Fulton, Maryland 20759

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory

Date

2/23/2011

20c. Location - City or Town, State

Woodbine, Maryland

21. Signature of Funeral Service Licensee

Juanita R. Thomas

M00957

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784  
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Approximate Interval Between Onset and Death  
4 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

KRUKENBURG TUMOR WITH METASTASES

8 MONTHS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ADD MD PHYSICIAN

29c. License number

D50404

29d. Date signed (Month, Day, Year)

FEB 20, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKUSH D. PATEL 10632 LITTLE PATUXENT PARK #111 COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Sandra J. Spaw

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05748

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KATHLEEN ELIZABETH BRADLEY

2. Date of Death

Month Day Year  
February 20 2011

3. Time of Death

1:34 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

215-64-9170

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep 26, 1944

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 E. 16th Street

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Wholesale Perfumer

16b. Kind of Business Industry

Gift Industry

17. Father's Name (First, Middle, Last)

John Charles Bradley

18. Mother's Name (First, Middle, Maiden Surname)

Martha Elizabeth Rogers

19a. Informant's Name/Relationship (Type, Print)

Martha E. Hamel-Huff/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Main Street Walkersville, Maryland 21793

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory

Date

2/23/2011

20c. Location - City or Town, State

Woodbine, Maryland

21. Signature of Funeral Service Licensee

Juanita R. Thomas

M00957

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 784  
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BREAST CANCER

Approximate Interval Between Onset and Death

MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D0062223

29d. Date signed (Month, Day, Year)

2/21/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLAVEREN BOLANUM, 196 TJOLIVE, FREDERICK MD 21702

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item 26 per verb., g912, 02/25/2011 dbb

Reg. No.

2011 05749

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Alverta C. Butler</b>  |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>21</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>6:05a</b> M   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Emerald Estates</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-20-6427</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 25, 1923</b> | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |
|  | Usual Residence of Decedent   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>1237 North Luzerne Avenue</b>  |  | 10f. Zip Code<br><b>21213</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b> |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postman</b>   |  | 16b. Kind of Business Industry<br><b>Federal Post Office</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Willie Wiggins</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alverta Wiggins</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Consuela Davis</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2520 Lauretta Avenue Baltimore, Maryland 21213</b>  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans Cemetery</b>                                      |  | 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Service, P.A.<br/>1300 Eutaw Place Baltimore, Md 21217</b>                                |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypertensive Cerebrovascular Disease</b><br>Approximate Interval Between set and Death |  |   |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pulmonary Disease</b><br><b>Cerebrovascular Accident</b><br>23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |   |  |  |
| 25. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>  |   |  |   |  |  |
| 26. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   |  |  |
| 27. Date of Injury (Month, Day, Year)<br><b>2/22/2011</b>  |   |  |   |  |  |
| 28. Time of injury<br><b>M</b>   |   |  |   |  |  |
| 29. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>6717 Park Heights Ave - 21215</b>   |   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |  |   |  |  |
| 29c. License number<br><b>D 21680</b>  |   |  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/22/2011</b>  |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6717 Park Heights Ave - 21215</b>   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |   |  |   |  |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Known as Alverta C. Butler

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 7/2009

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

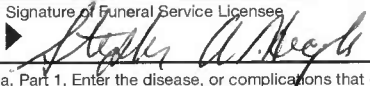
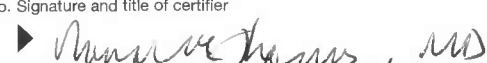
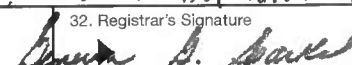
2011 05750

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mildred Irene Bramer</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>20</b> Year <b>2011</b>  |  |  |  | 3. Time of Death<br><b>4:15 P M</b>  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>2504 Red Maple Drive</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Abingdon</b>   |  |  |  | 4c. County of Death<br><b>Harford</b>  |  |  |  |
| 5. Social Security Number<br><b>214-32-0919</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 4, 1934</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  |   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Abingdon</b>   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2504 Red Maple Drive</b>  |  |   |  | 10f. Zip Code<br><b>21009</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>  |  |  |  | 16b. Kind of Business Industry<br><b>Health Care</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John (unk) Horst</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred (unk) Silkworth</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia R. Hyson/Daughter</b>  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2506 Red Maple Drive, Abingdon, MD 21009</b> |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>2-24-11</b>   |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, MD 21009</b>  |  |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):  |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>   |  |   |  |   |  |  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br> MD   |  |  |  | 29c. License number<br><b>D0026318</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>02-21-2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Donald E. Thomas, MD 3445 E. Bay Hill Corporate Center Drive, Arlington, Md. 21009</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

DHMM 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Roland Bulette

2. Date of Death  
Month Day Year  
February 21, 20113. Time of Death  
7:27 a MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

212-26-8469

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Nov. 11, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1202 Montreal Drive

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electronics Technician

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Hugh (unk) Bulette

18. Mother's Name (First, Middle, Maiden Surname)

Florence Edith Burkentine

19a. Informant's Name/Relationship (Type, Print)

Cindy J. McLeod / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

808 5th. Ave., Brunswick, MD 21716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harford Memorial Gdns. 2-25-11

Date

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

Charles A. Bulette

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, MD 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Thomas A. Biddle

29c. License number

042800

29d. Date signed (Month, Day, Year)

2/21/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas A. Biddle, 251

Leah's Way, H &amp; G, MD, 21078

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Thomas A. Biddle

State  
Registrar

0727

2/21/11

Bulette, Charles

5+1

H

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05752

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Betty V. Brunt

2. Date of Death

February 18 2011

3. Time of Death

11:18 P.M.

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216-24-8425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

8. Date of Birth (Month, Day, Year)

Feb 22, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1102 Druid Hill Avenue

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housekeeper

16b. Kind of Business/Industry

Maryland General Hospital

17. Father's Name (First, Middle, Last)

William Brandford

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Brandford

19a. Informant's Name/Relationship (Type, Print)

Diane Sparrow

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1618 North Hilton - B-1 Baltimore, Maryland 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National Cemetery

Date

02/25/11

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.  
1300 Eutan Place Baltimore, Md 21217

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0058141

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendie Williams, MD 900 S. Caton Avenue Baltimore, MD 21229

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05753

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROBERT J. BAKER, JR.

2. Date of Death

Month Day Year  
FEBRUARY 21, 2011

3. Time of Death

4:25 P.M.

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

5. Social Security Number

212-20-5614

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

8. Date of Birth (Month, Day, Year)

7/19/1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PARKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2808 KINGS RIDGE ROAD APT. C

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8TH GRADE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

EXAMINER

16b. Kind of Business Industry

SOCIAL SECURITY ADMINISTRATION

17. Father's Name (First, Middle, Last)

ROBERT J. BAKER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY MILLER

19a. Informant's Name/Relationship (Type, Print)

ROBERT J. BAKER, III/SOON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2808 KINGS RIDGE RD. APT. C BALTIMORE, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

2/23/2011

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

MOO217

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

R149192

29d. Date signed (Month, Day, Year)

2/24/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES CAMP 2300 DULANEY VALLEY RD TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

February 21, 2011 4:25pm  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

2011 05754

1- For State Registrar

Certificate of Death

Reg. No.

|   |  |   |   |  |   |  |
|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>KARL FREDERICK BALLWANZ, JR.</b>                |   | 2. Date of Death<br>Month <b>February</b> Day <b>21</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>6:45 P M</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland Masonic Home</b> |   | 4b. City, Town, or Location of Death<br><b>Cockeysville</b>   |  | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-18-6559</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.            |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>March 25, 1922</b>                                   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| Usual Residence of Decedent   |  |   |   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><b>1700 Webster Street</b>  |  |   | 10f. Zip Code<br><b>21230</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW 2</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Labor Management</b>  |  | 16b. Kind of Business/Industry<br><b>National Can Corp.</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>Karl Frederick Ballwanz, Sr.</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Elizabeth Auer</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dolores Helen Ballwanz (WIFE)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21030 Maryland Masonic Home, 300 International Circle, Cockeysville, Md.</b> |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |   | Date<br><b>Feb. 25, 2011</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br>   |  | Kevin E Ecker   |   | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary Heart Failure</b><br>Due to (or as a consequence of):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   | Approximate Interval Between Onset and Death   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month Day Year                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Diabetes, Hic Stroke, Cholesterol</b><br><b>Hypothyroidism</b>   |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death Check only one<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28d. Describe how injury occurred  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><br><b>R.T. Liberto, M.D.</b>  |  |   | 29c. License number<br><b>D21464</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-22-11</b>       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert T. Liberto 3508 Bank Street Baltimore, Md. 21224</b>  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  | 32. Registrar's Signature<br>   |   |  |   |  |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

10 + 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05755

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Levon Michael Brown

2. Date of Death

Month Day Year  
February 19, 2011

3. Time of Death

0425 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

SB I - 95 @ mile marker 76.3

4b. City, Town, or Location of Death

Abingdon

4c. County of Death

Harford

5. Social Security Number

052-68-2423

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

05/06/1983

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

NY

10b. County

N/A

10c. City, Town or Location

Brooklyn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

334 Chauncey Street

10f. Zip Code

11233

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11th Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Leon Brown

18. Mother's Name (First, Middle, Maiden Surname)

Leslie Hogan

19a. Informant's Name/Relationship (Type, Print)

Antoinette Graham(aunt)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1805 Roswell Rd., Marietta, GA 30062

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

on-site Crematory

Date

02/23/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home PA  
2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Feb 19, 2011

28b. Time of Injury

0415 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Interstate/Express

28d. Describe how injury occurred

Pedestrian struck by autos

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SB I - 95 @ mile marker 76.3, Abingdon, Md.

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 19, 2011

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

ORIGINAL

OCME

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05756

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mack Emory Caudill</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>23</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>6:30 A M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>707 Calvary Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Churchville</b>  |  | 4c. County of Death<br><b>Harford</b>  |  |
| 5. Social Security Number<br><b>246-38-7788</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 3, 1924</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  | Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Churchville</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>707 Calvary Road</b>   |  |   |  | 10f. Zip Code<br><b>21028</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner/Operator</b>  |  | 16b. Kind of Business Industry<br><b>Barber</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joe Clark Caudill</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mae E. Edwards</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anita M. Reedy / Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1324 Harford Square Drive, Edgewood, Maryland 21040</b>                                       |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gdn</b>   |  | Date<br><b>2-26-11</b>  |  | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>EOSINOPHILIC INTERSTITIAL NEPHRITIS</b><br>Due to (or as a consequence of):<br><b>NOT KNOWN</b><br>Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>FEW MONTHS</b>   |  |   |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b><br><b>HTN</b><br><b>PROSTATE CANCER</b>   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br><b>- - -</b>  |  | 28b. Time of injury<br><b>- - M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred<br><b>-</b>   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D0060532</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-24-11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANURAG SOOD 19 WALNUT LANE ABERDEEN 21001</b>  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05757

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Jerome C. Cohen

2. Date of Death

Month Day Year  
02 23 2011

3. Time of Death

11:12 A M

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

043-36-7696

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

8. Date of Birth  
(Month, Day, Year)

10/09/1945

9. Birthplace (State or Foreign Country)

CT

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6807 PARK HEIGHTS AVENUE, #1E

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business Industry

EDUCATION

17. Father's Name (First, Middle, Last)

MAXWELL HARRY COHEN

18. Mother's Name (First, Middle, Maiden Surname)

NINA

GOLDSTEIN

19a. Informant's Name/Relationship (Type, Print)

CAROLE COHEN / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6807 PARK HEIGHTS AVENUE, #1E, BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of Facility)

FLEMING SIZEMORE  
SHOMREI HADATH

Date

2/24/2011

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Neutropenia

Due to (or as a consequence of):

c. Lung adenocarcinoma, stage IV

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 day

2 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Central diabetes insipidus,  
Insulin dependent diabetes mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Milos Miljkovic, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

02/23/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Milos Miljkovic, MD Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05758

1 For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTOPHER LEE CANAPP

2. Date of Death  
Month Day Year

February 21 2011

3. Time of Death

5:32 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

219-96-1783

6. Sex  
1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/22/1981

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4371 CRESTHEIGHTS ROAD

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ALBERT CANAPP JR.

18. Mother's Name (First, Middle, Maiden Surname)

DEBRA

LAMBERT

19a. Informant's Name/Relationship (Type, Print)

MINDY CLARK / FIANCEE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4371 CRESTHEIGHTS ROAD, BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BALTIMORE HEBREW CONG.

Date

02/25/2011

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

Michael Kruger

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN ROAD, PIKESVILLE, MD 2120823a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Anoxic Brain Injury

Due to (or as a consequence of):

b. Acute Asthmatic Exacerbation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death  
8 days

8 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Chronic Kidney Disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Herrera

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

February 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Guadalupe Herrera-Garcia D.O.

Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

D. Herrera

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05759

## 1- For State

Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Rashawd Davenport

2. Date of Death

Month Day Year  
February 20, 2011

3. Time of Death

0319 hrs

4a. Facility Name (if not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

213-17-1704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

23 Yrs.

If Under 1 Year

Months

If Under 24Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

7/23/1987

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6500 Loch Hill Road

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouseman

16b. Kind of Business/Industry

Port City Press

17. Father's Name (First, Middle, Last)

Roy Roosevelt Davenport III

18. Mother's Name (First, Middle, Maiden Surname)

Annette Bowman

19a. Infant's Name/Relationship (Type, Print)

Ms. Annette Bowman (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16500 Loch Hill Rd. Balt., MD 21239

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenwood Cemetery

Date

3/1/2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Patricia L. Harris &amp; M.

22. Name and Address of Facility

Joseph L. Russ Funeral Home P.A.  
2222 W. North Ave. Balt., MD 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

UNPENDED

AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

Feb 20, 2011

28b. Time of Injury

0241 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Multi-Family Apt.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5122 Sekots Road Apt. B2, Baltimore, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ana Rubio

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 20, 2011

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Rashawd Davenport

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05760

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |   |  |  |
|--|--|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ann L. Dorsey</b>   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>21</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>8:55 PM</b>  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Northwest Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |   | 4c. County of Death<br><b>Baltimore</b>   |  |  |
| 5. Social Security Number<br><b>219-32-2555</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>April 2, 1936</b>   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>   |  |  |
| Usual Residence of Decedent  |  |   |   |   |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Pikesville</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
| 10e. Street and Number<br><b>504 Shamrock Lane</b>   |  | 10f. Zip Code<br><b>21208</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+)  |   |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>   |  | 16b. Kind of Business Industry<br><b>Own Home</b>   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Benjamin Baker</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Stanley</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Calvin Dorsey / HUSBAND</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>504 Shamrock Lane, Pikesville, MD 21208</b> |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory INC.</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Patrik Fleming</b>   |  | 22. Name and Address of Facility<br><b>Cremation Society Of Maryland INC<br/>299 Frederick Road, Catonsville, MD 21228</b>  |   |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>non small cell Lung cancer</b>   |  |   |   |   | Approximate Interval Between Onset and Death   |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Due to (or as a consequence of):<br>a. <b>non small cell Lung cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                    |  |   |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   | 23d. Date of delivery<br>Month Day Year   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Home</b> |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Chad O'Donnell MD</b>  |  | 29c. License number<br><b>D15872</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Feb 22, 2011</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Warren BCB 6934 Arlington Blvd Suite A 21061</b>  |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br><b>James B. Sparks</b>   |   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05762

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Lisa Domanski

2. Date of Death

February 13, 2011

3. Time of Death

1030 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Baltimore Washington Medical Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

220.86.8267

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42

Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24Hrs.

8. Date of Birth (MM/DD/YYYY)

Dec 26, 1968

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

906 Dorking Rd.

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Hopkins

18. Mother's Name (First, Middle, Maiden Surname)

Juanita Bowings

19a. Informant's Name/Relationship (Type, Print)

Theodore Domanski Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

906 Dorking Rd., Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

FEB 21, 2011

20c. Location - City or Town, State

Brooklyn Park, MD

21. Signature of Funeral Service

K. Gregory Fink

MO1148

22. Name and Address of Facility

Fink Funeral Home, P.A.

426 Crain Hwy S., Glen Burnie, MD 21061

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cocaine and oxycodone intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED

23a, 27, 28a-f, per ME g913 3/3/11 TT

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☒ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☒ Could not be determined

28a. Date of Injury (Month, Day, Year)

fd 2/13/11

28b. Time of Injury

fd 9:30 am

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unk

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) fd: residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

906 Dorking Rd

Glen Burnie, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ling Li, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 14, 2011

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Ling Li, MD

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

17903

ill

OKed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05763

1 For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Gloria Donohue

2. Date of Death

Month Day Year  
Feb 20, 2011

3. Time of Death

9:43 A M

4a. Facility Name (if not institution, give street and number)

204 Agnes Ct.

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

212-28-9696

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 8, 1931

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

204 Agnes Ct.

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Larkin

18. Mother's Name (First, Middle, Maiden Surname)

Syleste Mason

19a. Informant's Name/Relationship (Type, Print)

Jim Donohue Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

204 Agnes Ct., Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

New Cathedral Cemetery

Date

Feb 24, 2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

K. Gregory Fink

M01148

22. Name and Address of Facility

Fink Funeral Home, P.A.

426 Crain Hwy S., Glen Burnie, MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

Approximate interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Neil E. Lodge MD

29c. License number

D0033296

29d. Date signed (Month, Day, Year)

2/24/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2711 Quarterfield Rd Glen Burnie MD 21061

31. Date of Death (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Jennifer B. Spauld

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05764

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles B. Dickinson, Jr.

2. Date of Death

February 21, 2011

3. Time of Death

0530 AM

4a. Facility Name (If not institution, give street and number)

Somerford Assisted Living

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

578-07-0342

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

8. Date of Birth (Month, Day, Year)

September 18, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8811 Lowell Place

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Corporate Secretary

16b. Kind of Business/Industry

Washington Gas Light Co.

17. Father's Name (First, Middle, Last)

Henry Nelson Dickinson

18. Mother's Name (First, Middle, Maiden Surname)

Ella Martin McCarty

19a. Informant's Name/Relationship (Type, Print)

Charles Bruce Dickinson, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11605 Ten Penny Drive, Fairfax Station, Virginia 22039

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.,

Date

February 22, 2011

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

John J. Pumphrey M01360

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Vascular Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William F. Bode

29c. License number

0056826

29d. Date signed (Month, Day, Year)

February 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. Bode, 1111 Paul Street, Bethesda, MD 20814

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

John B. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
Registrar

Amend Item 25

State of Maryland / Department of Health and Mental Hygiene

per me, g912,02/25/2011 dnb

Certificate of Death

Reg. No.

2011 05765

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Joyce Elaine Eversole

2. Date of Death

Month

Day

Year

3. Time of Death

2232 M

4a. Facility Name (if not institution, give street and number)

Western Maryland Health System

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

214-42-0703

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
March 6, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

10c. City, Town or Location

Bedford

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

570 Evitts Creek Rd

10f. Zip Code

15522

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

secretary

16b. Kind of Business Industry

fitness center

17. Father's Name (First, Middle, Last)

William Carter

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Carter

19a. Informant's Name/Relationship (Type, Print)

Robert Eversole - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

570 Evitts Creek Rd; Bedford, Pennsylvania 15522

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Director

Ronald S. Wade, Director

22. Home and Address of Facility

State Anatomy Board  
655 W. Baltimore St; Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute brainstem hemorrhage  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Type II Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☒ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be determined  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

01/26/2011

28b. Time of Injury

2250 M

28c. Injury at work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Pt. fell in her bathroom hitting her head.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

At home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

570 Evitts Creek Road Bedford, PA 15522

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Christopher Vagnoni MD

29c. License number

D0059987

29d. Date signed (Month, Day, Year)

1/28/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER SCOTT VAGNONI WESTERN MD. HEALTH SYSTEM CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

James A. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05766

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Darlene

Edmond

2. Date of Death

Month Day Year  
February 19<sup>th</sup> 2011

3. Time of Death

LO: 5:50pm

4a. Facility Name (if not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

241-64-5939

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

Month Day Year  
5/3/1935

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1339 N. Fulton Ave.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Johnnie Mack Whitfield

18. Mother's Name (First, Middle, Maiden Surname)

Sally Bullock

19a. Informant's Name/Relationship (Type, Print)

Ms. Phebe Johnson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1339 N. Fulton Ave. Balto., MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

3/2/2011

20c. Location - City or Town, State

Lansdowne, MD

21. Signature of Funeral Service Licensee

Patricia L. Harris L.M.

22. Name and Address of Facility

Joseph North Ave. Balto., MD 21216

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

Bowel Perforation

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

COPD

Diabetes

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael S. Ballo M.D.

29c. License number

D56226

29d. Date signed (Month, Day, Year)

February 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael S. Ballo, 5401 Old Court Rd. Randallstown, Maryland 21133

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Diana J. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT J EYRING

2. Date of Death  
Month Day Year  
February 8 2011

3. Time of Death

2:10 AM

4a. Facility Name (if not institution, give street and number)

JOHN HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

220-42-7011

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

JUNE 26, 1944

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTO.

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

713 MILDAM RD.

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CASHIER

16b. Kind of Business Industry

SUPER FRESH

17. Father's Name (First, Middle, Last)

WILLIAM EYRING SR.

18. Mother's Name (First, Middle, Maiden Surname)

GRACE GUEMPLE

19a. Informant's Name/Relationship (Type, Print)

PATRICIA KEENE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2215 LAWELLS GLEN RD. BALTO. MD 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ATLANTIC CREM.

Date

2-15-11

20c. Location - City or Town, State

GLEN BURNIE

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA F.H. 2829 HUDSON ST 2124

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

b. BOWEL PERFORATION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

0 MINUTES

28 HOURS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ken Z...

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

FEBRUARY 8, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KEVIN ZHANG, MD, 4940 EASTERN AVENUE, BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.


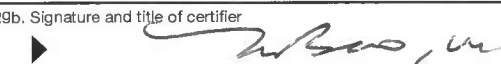
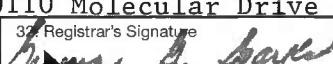
State of Maryland / Department of Health and Mental Hygiene

2011 05768

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |   |  |  |
|---|---|--|--|--|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Geraldine Mildred Englund</b>  |  |  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>22</b> Year <b>2011</b>       |   | 3. Time of Death<br><b>12:10 P M</b>   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Suburban Hospital</b>  |  |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                        |   | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>550-38-3030</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 18, 1919</b>                    |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                    |  |
|   | Usual Residence of Decedent   |  |  |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Bethesda</b>  |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>5017 Del Ray Avenue</b>  |  |  |  | 10f. Zip Code<br><b>20814</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                          |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>  |  |  | 16b. Kind of Business Industry<br><b>Medicine</b>                       |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Lando</b>  |  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Rosenshine</b> |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gretchen Koitz / Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5017 Del Ray Avenue Bethesda, Maryland 20814</b>  |  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>  |  | 20c. Date<br><b>February 25, 2011</b>   |  | 20d. Location - City or Town, State<br><b>Bethesda, Maryland</b>               |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc.<br/>7557 Wisconsin Avenue Bethesda, Maryland 20814</b>           |  |   |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PNEUMONIA</b>   |  |  |  |   |  |  |   |  |  |
|   | 23b. Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |  |   |  |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |   |  |  |  |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |  |  |   |  |  |
| 29a. Certifier<br>(Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. Signature and title of certifier<br><br>29c. License number<br><b>D0057124</b><br>29d. Date signed (Month, Day, Year)<br><b>2/23/11</b> |   |  |  |  |   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Truong Bao, M.D. 10110 Molecular Drive #206 Rockville, Maryland 20850</b>  |   |  |  |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b><br>32. Registrar's Signature<br>   |   |  |  |  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Geraldine Englund 2/22/11 1210

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 05769

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

|  |  |   |  |                              |
|--|--|---|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br>Daniel Patrick Ernst |  | 2. Date of Death<br>Month Day Year<br>February 20, 2011 |  | 3. Time of Death<br>1847 hrs |
|--|--|---|--|------------------------------|

Funeral  
Director

|   |  |   |  |                                     |
|---|--|---|--|-------------------------------------|
| 4a. Facility Name (if not institution, give street and number)<br>7862 Americana Circle, Apt. 201 |  | 4b. City, Town, or Location of Death<br>Glen Burnie |  | 4c. County of Death<br>Anne Arundel |
|---|--|---|--|-------------------------------------|

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 5. Social Security Number<br>213-13-4064 | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>24 Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br>05/02/1986 | 9. Birthplace (State or Foreign Country)<br>Michigan |
|--|--|---|---|---|--|

|                             |  |                             |  |  |
|-----------------------------|--|-----------------------------|--|--|
| Usual Residence of Decedent |  | 10c. City, Town or Location |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|-----------------------------|--|-----------------------------|--|--|

|                        |                             |   |                        |   |
|------------------------|-----------------------------|---|------------------------|---|
| 10a. State<br>Maryland | 10b. County<br>Anne Arundel | 10c. City, Town or Location<br>Pasadena | 10f. Zip Code<br>21122 | 10g. Citizen of What Country?<br>U.S.A. |
|------------------------|-----------------------------|---|------------------------|---|

|  |  |                        |  |   |
|--|--|------------------------|--|---|
| 10e. Street and Number<br>1251 Castine Court |  | 10f. Zip Code<br>21122 |  | 10g. Citizen of What Country?<br>U.S.A. |
|--|--|------------------------|--|---|

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|--|--|--|--|---|--|--|--|

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|--|--|---|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 N/A |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Server |  | 16b. Kind of Business/Industry<br>Restaurant |  |
|--|--|---|--|--|--|

|  |  |   |  |
|--|--|---|--|
| 17. Father's Name (First, Middle, Last)<br>James Patrick Ernst |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Neysa Paula McHugh |  |
|--|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Neysa P. Ernst (Mother) |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1251 Castine Court Pasadena, Maryland 21122 |  |
|---|--|--|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Cross Cem. |  | 20c. Location - City or Town, State<br>Brooklyn Park, MD |  |
|--|--|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> |  | 22. Name and Address of Facility<br>McCully-Polyniak Funeral Home, P.A.<br>3204 Mountain Road Pasadena, Maryland 21122 |  |
|---|--|--|--|

|   |  |  |  |
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| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  | Approximate Interval Between Onset and Death |  |
|---|--|--|--|

|   |  |  |  |
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| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Necrotizing Bronchopneumonia</b><br>Due to (or as a consequence of): |  |  |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. Due to (or as a consequence of): |  |  |  |
|---|--|--|--|

|                                     |  |  |  |
|-------------------------------------|--|--|--|
| d. Due to (or as a consequence of): |  |  |  |
|-------------------------------------|--|--|--|

|   |  |                                |  |
|---|--|--------------------------------|--|
| <input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  | 23a, 27 per me g914 4-13-11 vt |  |
|---|--|--------------------------------|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
|--|--|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |  |  |  |
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| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other: Scene |  |
|---|--|--|--|

|   |  |  |  |                     |  |  |  |                                   |  |
|---|--|--|--|---------------------|--|--|--|-----------------------------------|--|
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|---|--|--|--|---------------------|--|--|--|-----------------------------------|--|

|  |  |  |  |
|--|--|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
|--|--|--|--|

|  |  |   |  |                                 |  |  |  |
|--|--|---|--|---------------------------------|--|--|--|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Ana Rubio</i> |  | 29c. License number<br>O.C.M.E. |  | 29d. Date signed (Month, Day, Year)<br>February 21, 2011 |  |
|--|--|---|--|---------------------------------|--|--|--|

|   |  |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |  |
|---|--|

|  |  |   |  |
|--|--|---|--|
| 31. Date filed (Month, Day, Year)<br>FEB 25 2011 |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |
|--|--|---|--|

|                 |  |
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| State Registrar |  |
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| Baltimore, MD 21215-0036 |  |
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| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. |  |
|--|--|

|  |  |
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| To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit |  |
|--|--|

|  |  |
|--|--|
| Medical Certification: To Be Completed by Physician/Medical Examiner |  |
|--|--|

|  |  |
|--|--|
| Division of Vital Records, P.O. Box 68760, |  |
|--|--|

|          |  |
|----------|--|
| ORIGINAL |  |
|----------|--|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05770

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lydia O'Neal Stewart Fraser

2. Date of Death

February 19, 2011

3. Time of Death

6:45 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

220-56-5577

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 9, 1950

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2827 Arizona Avenue, N.W.

10f. Zip Code

20016

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Legal Secretary

16b. Kind of Business Industry

Law Firm

17. Father's Name (First, Middle, Last)

William David Stewart Fraser, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lydia O'Neal

19a. Informant's Name/Relationship (Type, Print)

Anne Fraser/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5310 Manning Place, N.W., Washington, D.C. 20016-5310

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Montgomery

Crematorium, Inc.

Date

February 22,

2011

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/ Chase, Inc.

7557 Wisconsin Ave., Bethesda, Maryland 20814-3501

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urinary Tract Infection

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Renal Failure

Due to (or as a consequence of):

3 days

c. Hepatocellular Carcinoma - metastasis

Due to (or as a consequence of):

months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mike Murray, MD

29c. License number

70144

29d. Date signed (Month, Day, Year)

February 19, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Murray MD 9901 Medical Ctr Dr Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Sergey B. Spalek

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|                                     |  |   |   |  |   |  |   |  |  |  |  |  |
|-------------------------------------|--|---|---|--|---|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Deborah Grubb</b>   |   |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>19</b> Year <b>2011</b>  |  |   |  | 3. Time of Death<br><b>7:57 p M</b>  |  |  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  |   |  | 4c. County of Death<br><b>Baltimore</b>  |  |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>218-78-4568</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.  |  | 8. Date of Birth (Month Day Year)<br><b>6/9/1964</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
|                                     | Usual Residence of Decedent  |   |   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Parkville</b>   |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
|                                     | 10e. Street and Number<br><b>1 Venus Court Apt K</b>   |   |   |  | 10f. Zip Code<br><b>21234</b>   |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|                                     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary (Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Counselor</b>   |  |   |  | 16b. Kind of Business Industry<br><b>Baltimore Behavior Center</b>   |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Percy Grubb</b>  |   |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Gladys Johnson</b>   |  |  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print) (Sister)<br><b>Ms. Ruzara Bey</b>   |   |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1412 Gittings Ave. Balto., MD 21239</b> |  |  |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |  |   |  | 20c. Date<br><b>2/25/2011</b>  |  |  |  |
|                                     | 20d. Location - City or Town, State<br><b>Woodlawn, MD</b>   |   |   |  | 21. Signature of Funeral Service Licensee<br><b>Odyssey Gray</b>  |  |   |  | 22. Name and Address of Facility<br><b>Joseph E. Russ Funeral Home, P.A.<br/>2232 W. North Ave. Balto., MD 21216</b>   |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>hepatic failure</b><br>a. Due to (or as a consequence of):<br><b>Lupus</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |  |   |  |   |  |  |  |  |  |
|                                     | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lupus Nephritis with End Stage Kidney disease</b><br><b>Disseminated Intravascular Coagulation</b>   |   |   |  |   |  |   |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |
|                                     | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |   |  |   |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|                                     | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |   |  |   |  |   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
|                                     | 28a. Date of injury (Month, Day, Year)   |   |   |  | 28b. Time of injury<br><b>M</b>   |  |   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|                                     | 28d. Describe how injury occurred  |   |   |  |   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |   |  |   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
|                                     | 29b. Signature and title of certifier<br><b>Mark Gosnell MD</b>  |   |   |  | 29c. License number<br><b>DC058082</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>2/20/11</b>  |  |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mark Gosnell 6535 N. Charles, N. Pavilion Suite 552, Towson, MD 21204</b>   |   |   |  |   |  |   |  |  |  |  |  |
|                                     | State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b> |   |  |   | 32. Registrar's Signature<br><b>Ann B. Jones</b> |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16a, per FH, G912, 2/25/2011, WS  
State of Maryland / Department of Health and Mental Hygiene  
amend #5 Per FH G913 3/08/2011 JH  
Certificate of Death

2011 05772

1- For  
State  
Registrar

Reg. No.

|  |   |  |   |   |  |  |  |  |
|--|---|--|---|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Myrtice Graham</b>   |  |   | 2. Date of Death<br>Month <b>February</b> Day <b>22</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>1300 PM</b>   |  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Harbor Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |  |
| Funeral<br>Director  | 5. Burial Service Number<br><b>217-74-3762</b><br><b>217-74-3752</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 28, 1958</b>                                       |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>2429 Westport St</b>   |  |   | 10f. Zip Code<br><b>21230</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired.)<br><b>Baltimore City Public School</b>     |   | 16b. Kind of Business Industry<br><b>Food Service</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Robert Thomas</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothea Copeland</b>   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Graham</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2429 Westport St, Baltimore, MD 21230</b> |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Park</b>  |   | Date<br><b>3/2/2011</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Bruce A. Amos Jr.</b>   |  | 22. Name and Address of Facility<br><b>Howell Funeral Home</b><br><b>4600 Liberty Heights Ave, Balto MD 21209</b>                                     |   |  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. <b>Due to (or as a consequence of):</b><br>c. <b>Due to (or as a consequence of):</b><br>d. <b>Due to (or as a consequence of):</b> |  |   |   |  |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Emphysema</b><br><b>Diabetes</b>   |   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28d. Describe how injury occurred   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>A. Stevenson, MD</b>   |   |  | 29c. License number<br><b>D68793</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 22, 2011</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Karen Stevenson, MD Harbor Hospital 3001 S Hanover St., Baltimore, MD 21225</b>   |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |   | 32. Registrar's Signature<br><b>Karen A. Stevenson</b>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05773

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Willie R. Gross</b>   |  |   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>23</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>12:04 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>260-30-1224</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 3, 1929</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>G-A</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>3513 Ellamont Rd</b>  |  |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerical</b>   |  | 16b. Kind of Business/Industry<br><b>Bragger Gutmaus</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Rachel</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jewel Booker Rachel</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John A. Gross</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3513 Ellamont Rd, Baltimore, MD 21215</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |  | 20c. Date<br><b>3/1/2011</b>   |  | 20d. Location - City or Town, State<br><b>Owings Mills, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |   |  | 22. Name and Address of Facility<br><b>Howell Funeral Home 4600 Liberty Heights Ave, Balto MD 21207</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiopulmonary arrest</b><br>Due to (or as a consequence of):<br>a. <b>arrhythmia</b><br>Due to (or as a consequence of):<br>b. <b>chronic disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |  |   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>   |  |   |  | 29c. License number<br><b>D64707</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/24/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ruth Love MD Sinai ER 2401 W. Belvedere, Balto MD 21215</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 23 2011</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State  
Registrar

ORIGINAL



Physician/  
Medical ExaminerFuneral  
Director1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Clarence Gollahon

2. Date of Death

Month Day Year  
February 6, 2011

3. Time of Death

1630 hrs

4a. Facility Name (if not institution, give street and number)

3816 Fairhaven Avenue 2nd Floor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218 80 0567

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

06/23/1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3816 Fairhaven Avenue 2nd Floor

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Auto Repair

17. Father's Name (First, Middle, Last)

Isaac Ray Gollahon

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Joyce Weiford

19a. Informant's Name/Relationship (Type, Print)

Lisa M. Gollahon / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3615 Mt. Ida Drive Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

02/23/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Service, P.A.  
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED 23a, pt. II, 27 per me g914 4-13-11 vt

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

methadone use

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

State Registrar

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

17905

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Irene Goforth</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>10:35 AM</b>   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>115 Lake Street</b>  |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>412-72-5261</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 5, 1919</b> |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b>  |  | Usual Residence of Decedent   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>TN</b>   | 10b. County<br><b>Henry</b>  | 10c. City, Town or Location<br><b>Paris</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>1101 Volunteer Drive Unit 209</b>  |  | 10f. Zip Code<br><b>38242</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)                           |  |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business Industry<br><b>Own Home</b>   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas Henry Ball</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theadus Rainwaters</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret S. Daily (Daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 Lake Street Gaithersburg, MD 20878</b>        |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Memorial Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Paris, TN</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Ridgeway Funeral Home<br/>201 Dunlap Street Paris, TN 38242</b>  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Malignant Cervical Cancer</b>   |  |   |  |   |
| 23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediate Cause (Final disease or condition resulting in death)</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |   |  |   |  |   |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown   |   |  |   |  |   |
| 23d. Date of delivery<br>Month Day Year   |   |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b><br><b>Diabetes Mellitus Type II</b><br><b>Hypertension</b>   |   |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |   |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Daughter's Residence</b>   |   |  |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |   |  |   |
| 28a. Date of injury (Month, Day, Year)  |   |  |   |  |   |
| 28b. Time of injury<br>M  |   |  |   |  |   |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |   |
| 28d. Describe how injury occurred   |   |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |   |
| 29b. Signature and title of certifier<br>   |   |  |   |  |   |
| 29c. License number<br><b>D45533</b>  |   |  |   |  |   |
| 29d. Date signed (Month, Day, Year)<br><b>February 18, 2011</b>   |   |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Daniel Snow, MD 15001 Dufief Mill Road North Potomac, MD 20878</b>   |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |   |  |   |  |   |
| 32. Registrar's Signature<br>   |   |  |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas H. Glorius

2. Date of Death

February 23 2011

3. Time of Death

7:16 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Baltimore Washington Medical Center  
St. Agnes Hospital

4b. City, Town, or Location of Death

Glen Burnie  
Baltimore

4c. County of Death

Anne Arundel

5. Social Security Number

578-42-8458

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04/05/1934

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

304 Maryland Ave.

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ NoIf Yes, Give  
Year or Dates. 1954-  
195513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Painter

16b. Kind of Business Industry

Home Improvement

17. Father's Name (First, Middle, Last)

Harry Glorius

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Cohen

19a. Informant's Name/Relationship (Type, Print)

April Montgomery / Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 Maryland Ave., Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

W. Arundel Crematory

Date

02/25/2011

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

Mal E. Fair

M01452

22. Name and Address of Facility

Bailey Funeral Home and Cremation Service, PA  
4023 Annapolis Rd., Halethorpe, MD 2122723a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
immediateSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George Durst

29c. License number

D0059914

29d. Date signed (Month, Day, Year)

February 23 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE DURST 1120 N. Rolling Road, Baltimore, Maryland 21228

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Lynne B. Jones

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE C. GROVES</b>   |  |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>23</b> , Year <b>2011</b>  |  | 3. Time of Death<br><b>3:10 P<sup>M</sup></b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Glen Burnie Health &amp; Rehabilitation Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>219-16-7170</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 23, 1925</b>                                       |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Pasadena</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>102 Crain Highway Apt. 963</b>   |  |  |  | 10f. Zip Code<br><b>21060</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>W.W. II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>N/A</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Boiler Operator</b>   |  | 16b. Kind of Business Industry<br><b>Dupont Corp</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Roland Groves</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Pumphrey</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris M. Groves (Wife)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 Crain Highway Apt 963 Glen Burnie, MD 21060</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Atlantic Cremation</b>  |  | Date<br><b>02/24/2011</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>                                |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home, P.A.<br/>3204 Mountain Road Pasadena, Maryland 21122</b>  |  |  |  |

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Parkinson's disease</b>   |  |  |  | Approximate Interval Between Onset and Death<br><b>8 yrs</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia<br/>Hypertension</b>   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of injury<br>M  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Whynae M. Attending Doctor</b>   |  | 29c. License number<br><b>D 21684</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/24/2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C.V. CYRIAC, M.D. 8021 RITCHIE HWY PASADENA, MD 21122</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br>  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
RegistrarAmend Item 23a per dr., g912, 02/25/2011 dnb  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

2011 05778

Patient known Hendricks Sallie B.

Baltimore, Maryland 21215-0036

Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sallie B. Hendricks</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 9 2011</b>   |  | 3. Time of Death<br><b>5:16 P M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |
| 5. Social Security Number<br><b>213-20-2523</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Sep 24, 1914</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>No Carolina</b>   |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4203 Groveland Avenue</b>   |  | 10f. Zip Code<br><b>21215</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>Own Home</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Medicus Hendricks</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dinah Rodwell</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Hendricks</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4203 Groveland Avenue Baltimore, Maryland 21215</b>  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Jordan Hill Church Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Macon, No. Carolina</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Leah Bley</b>  |  | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Service, P. A.<br/>1300 Eutaw Place Baltimore, Md 21217</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cardiac Arrest</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension</b><br><b>Hypertensive Cardiovascular Disease</b>   |  | 23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br><b>M</b>   |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Apur</b>   |  | 29c. License number<br><b>D28266</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/10/11</b>  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AYE LWIN. M.D. 2010 YORK RD, Balto, MD. 21212</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br><b>Debra A. Sparks</b>  |  |   |  |

2011 05779

1- For State Registrar

Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Gilda Jeraldine Henry</b>   |   | 2. Date of Death<br>Month <b>February</b> Day <b>16</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>8:00 A M</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Riverview Nursing Home</b>  |   | 4b. City, Town, or Location of Death<br><b>Essex</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-20-1694</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>March 21, 1918</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Essex</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>5 Brett Ct; #315</b>  |   | 10f. Zip Code<br><b>21221</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk 10</b> College (1-4or 5+) <b>unk 0</b>          |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>  |   | 16b. Kind of Business/Industry<br><b>Pharmacy</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Allegrini</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Jiakolini</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Debbie Malinowski - niece</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3127 East Ave; Baltimore, Maryland 21134</b>      |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |   | 22. Name and Address of Facility<br><b>State Anatomy Board<br/>655 W. Baltimore St; Baltimore, MD 21201</b>   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Clostridium difficile Colitis</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |   |   |  |  |
| 23b. IF FEMALE:<br>Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                                     |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] M.D.</b>  |  | 29c. License number<br><b>00055171</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>02/16/2011</b>     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sebastian K. John 3023 Eastern Avenue Baltimore MD 21224</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Laura Ann Harrison

2. Date of Death  
Month Day Year  
February 17, 20113. Time of Death  
1256 hrs

4a. Facility Name (if not institution, give street and number)

101 West Fayette Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

488-70-2941

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months Days

If Under 24Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

Aug. 2, 1956

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

Nevada

10b. County

Clark

10c. City, Town or Location

North Las Vegas

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

524 Round Reign Avenue

10f. Zip Code

89081

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Head Start Director

16b. Kind of Business/Industry

Acelero Learning Center

17. Father's Name (First, Middle, Last)

David C. Harrison

18. Mother's Name (First, Middle, Maiden Surname)

Allegra Lile

19a. Informant's Name/Relationship (Type, Print)

David C. Harrison (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11423 County Rd. 399 Hartsburg, MO 65039

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverview Cemetery

Date

2/25/2011

20c. Location - City or Town, State

Jefferson City, MO

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Freeman Mortuary  
915 Madison St., Jefferson City, MO 65101

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED 23a, 27 per me g913 3-1-11 vt

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Laura B. [Signature]

State  
RegistrarBaltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05781

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith E. Hendricks

2. Date of Death

Month Day Year  
Feb 22 2011

3. Time of Death

10:56 AM

4a. Facility Name (if not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

580-03-8311

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/20/1942

9. Birthplace (State or Foreign Country)

Virgin Islands

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5523 Seward Ave.

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
Registraramend items 10a-c,e,f per inf 8938 4-10-13 vt  
amend item 20b per fh 8912 2-25-11 vt  
State of Maryland, Department of Health and Mental Hygiene

Reg. No.

2011 05782

Certificate of Death

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lewis W. Jackson

2. Date of Death

February 20 2011 5:28 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

225-66-6477

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

8. Date of Birth

02-05-1947

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

DE MD. PG.

10b. County

PG.

10c. City, Town or Location

Washington

Oxon Hill

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1201 Southview Dr.

10f. Zip Code

20020 20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

College (1-4 or 5+)

17. Father's Name (First, Middle, Last)

Edwin Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Emily Coleman

19a. Informant's Name/Relationship (Type, Print)

Denise Jackson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2772 Bruce Pl..SE Washington, DC 20020

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

3-3-2011

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Charles McDonald

22. Name and Address of Facility

Ronald Taylor II Funeral home

10583 Middleport Ln Whiteplains, MD 20695

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ACUTE GANGRENE OF BOWEL

Approximate Interval Between Onset and Death

x Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

MASSIVE CEREBRAL VASCULAR ACCIDENT x month

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory H. Watson M.D.

29c. License number

D20629

29d. Date signed (Month, Day, Year)

2/22/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory H. Watson M.D. Watson R. Mel 2003

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Denise S. Jones

State  
Registrar

Jackson, Lewis M465558

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

12

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Elrich Johnson</b>   |   |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>21</b> Year <b>2011</b> |  | 3. Time of Death<br><b>5:55 AM</b>                         |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Loch Raven Community Living Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                 |  | 4c. County of Death<br><b>N/A</b>                          |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-50-7064</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.                         |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 14, 1950</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>1410 North Fulton Avenue</b>   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>1968 1970</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electronic Repairman</b>                    |  | 16b. Kind of Business Industry<br><b>Self Employed</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elrich D. Johnson Sr.</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alberta F. Johnson</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Crystal Johnson</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1410 North Fulton Avenue Baltimore, Maryland 21217</b>                                       |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>  |  | 20d. Date<br><b>03/01/11</b>   |  |  |
| 21. Signature of Funeral Service Lic. Reg.<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Service, P. A.<br/>1300 Eutaw Place Baltimore, Md 21217</b>                                   |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pancreatic Cancer</b>  |   |   |  |  |  |  |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |   |   |  |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   |   |  |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>   |   |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier<br>(Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>George E. Wicks M.D.</b>   |   | 29c. License number<br><b>D41365</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 21, 2011</b>  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George E. Wicks M.D.<br/>3900 Loch Raven Boulevard<br/>Baltimore, Maryland 21218</b>  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05784

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Thi Johnson

2. Date of Death

Feb 20 2011

3. Time of Death

09:00 AM

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

586-32-2716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/01/1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10 S. Catherine St.

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Home maker

16b. Kind of Business Industry

N/A

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

Christina Cooper (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1917 W. Baltimore, St., Baltimore, MD 21223

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

on-site Crematory

Date

02/25/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home PA  
2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Approximate Interval Between Onset and Death

5 minutes

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. John Cedeno MD

29c. License number

D0029968

29d. Date signed (Month, Day, Year)

FEBRUARY 20, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000 W. Baltimore St. Baltimore Maryland

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar



1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Raymond Keyser

2. Date of Death

Month Day Year  
February 23, 2011

3. Time of Death

6:27 A M

4a. Facility Name (if not institution, give street and number)

Harbor Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

218-42-4368

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 20, 1946

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Brooklyn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4207 4th Street

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

1960

1963

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business Industry

Trucking

17. Father's Name (First, Middle, Last)

Arthur Keyser

18. Mother's Name (First, Middle, Maiden Surname)

Ruth French

19a. Informant's Name/Relationship (Type, Print)

Wanda Keyser, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4207 4th Street Brooklyn, MD 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory Inc.

Date

02/24/11

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, Maryland 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

LARYNGEAL CANCER

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC HEART FAILURE ON DIALYSIS

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Purcell Hoff Physician

29c. License number

D19714

29d. Date signed (Month, Day, Year)

2/24/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL PIERRE THIBODEAU 4940 EASTERN AVE, BALTIMORE MD 21224

31. Date of Death (Month, Day, Year)

FEB 23 2011

32. Registrar's Signature

D. J. Davis

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

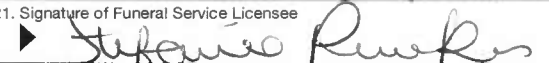
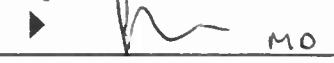

State of Maryland / Department of Health and Mental Hygiene

2011 05786

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Betty Jane Kiwakowski</b>   |  | 2. Date of Death<br>Month <b>02</b> - Day <b>20</b> - Year <b>2011</b>  |  | 3. Time of Death<br><b>0305 A M</b>   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Upper Chesapeake Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Bel Air</b>  |  | 4c. County of Death<br><b>Harford</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-36-9493</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>10-11-1939</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
|   | Usual Residence of Decedent  |  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Bel Air</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>1710 Redfield Rd</b>  |  | 10f. Zip Code<br><b>21014</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business Industry<br><b>Own Home</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Francis Hoare</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lenore (Unknown)</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Debra Amend (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1710 Redfield Rd Bel Air, MD 21014</b>        |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of Bel Air Inc 610 W. MacPhail Rd Bel Air, MD 21014</b>                             |  |   |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>unknown</b> |  |   |  |   |
| 23b. If female, Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown   |  |  |   |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |  |   |  |   |
| 23d. Date of delivery<br>Month Day Year   |  |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |   |  |   |
| 28a. Date of injury (Month, Day, Year)<br><b>February 20, 2011</b>  |  |  |   |  |   |
| 28b. Time of injury<br><b>M</b>   |  |  |   |  |   |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |
| 28d. Describe how injury occurred   |  |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |
| 29b. Signature and title of certifier<br> <b>MO</b>  |  |  |   |  |   |
| 29c. License number<br><b>D0065421</b>  |  |  |   |  |   |
| 29d. Date signed (Month, Day, Year)<br><b>February 20, 2011</b>   |  |  |   |  |   |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Christa Fisher, MD 500 Upper Chesapeake Drive Bel Air, MD 21014</b>  |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |  |   |  |   |
| 32. Registrar's Signature<br>  |  |  |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

5v

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05787

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Sean Joseph Kyle

2. Date of Death

Month Day Year  
February 22, 2011 6:00 PM

3. Time of Death

4a. Facility Name (if not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

5. Social Security Number

078-60-4282

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 27, 1960 New York

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7933 31st St.

10f. Zip Code

21237

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assembly Line

16b. Kind of Business Industry

General Motors

17. Father's Name (First, Middle, Last)

Joseph Kyle

18. Mother's Name (First, Middle, Maiden Surname)

Grace Falbo

19a. Informant's Name/Relationship (Type, Print)

Philomena Vondersmith /Aunt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3803 Perryhurst Dr. Nottingham, MD 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

Feb 24,  
2011

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Rebecca Hackerman

22. Name and Address of Facility

Cremation and Funeral Alternatives

8717 Green Pastures Drive Towson Maryland 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. LIVER CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jackie Jones

29c. License number

R149792

29d. Date signed (Month, Day, Year)

2/23/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Diana A. Spivey

State  
RegistrarFEBRUARY 22, 2011 6:00 p.m.  
Baltimore, Maryland 21215-0036permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transitSEAN KYLE  
Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05788

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |   |  |                                   |  |
|--|--|--|---|--|---|--|--|--|---|--|-----------------------------------|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Sheila Love</b>   |  |   |  | 2. Date of Death<br>Month <b>2</b> Day <b>22</b> Year <b>11</b> 14:13 M   |  |  |  | 3. Time of Death<br>M   |  |                                   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Washington Adventist Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Takoma Park MD</b>   |  |  |  | 4c. County of Death<br><b>Montgomery</b>  |  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>264-92-6747</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>09/05/53</b>                     |  | 9. Birthplace (State or Foreign Country)<br><b>Miami, FL</b>  |  |                                   |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |  |  |   |  |                                   |  |
| To Be Completed by Funeral Director                                | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PG</b>  |  | 10c. City, Town or Location<br><b>Hyattsville</b>   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                   |  |
|  | 10e. Street and Number<br><b>3517 Toledo Terrace #A</b>  |  |   |  | 10f. Zip Code<br><b>20782</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |                                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Medical Office Assistant</b>  |  |  |  | 16b. Kind of Business Industry<br><b>Washington Hospital Ctr.</b>   |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Elihue Love</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Genevia Joseph</b> |  |   |  |                                   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Genevieve Deweaver/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3517 Toledo Terrace #A Hyattsville, MD 20782</b>  |  |  |  |   |  |                                   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dade Memorial Park</b>   |  | Date<br><b>3-4-2011</b>  |  | 20c. Location - City or Town, State<br><b>Miami, Florida</b>  |  |                                   |  |
|  | 21. Signature of Funeral Service Lic. <i>Randa M. Maled</i>  |  |   |  | 22. Name and Address of Facility<br><b>Ronald Taylor II Funeral Home<br/>10583 Middleport Lane, White Plains, Maryland</b>  |  |  |  |   |  |                                   |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Stroke</b><br>Due to (or as a consequence of):<br>b. <b>HTN Emergency</b><br>Due to (or as a consequence of):<br>c. <b>CKD-V on Hemodialysis</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 hr</b><br><b>12 hrs</b><br><b>on going</b>                                  |  |   |  |   |  |  |  |   |  |                                   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |  |  |   |  |                                   |  |
| Physician/<br>Medical<br>Examiner                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CKD-V on H.D. Non complicant</b>  |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                   |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |  |                                   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |                                   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |   |  |                                   |  |
|  | 29b. Signature and title of certifier<br><i>Selassie</i>   |  |   |  | 29c. License number<br><b>D0066224</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>02/22/2011</b>  |  |                                   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Leelie Selassie Washington Adventist Hospital Takoma Park MD 20912</b>  |  |   |  |   |  |  |  |   |  |                                   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |   |  | 32. Registrar's Signature<br><i>Sandra S. Sparks</i>  |  |  |  |   |  |                                   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 05789

|   |   |  |   |  |  |  |
|---|---|--|---|--|--|--|
| Physician/<br>Medical Examiner  | 1. For State Registrar  |  | Reg. No.  |  | 3. Time of Death   |  |
|   | 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month Day Year<br>February 12, 2011   |  | 1552 hrs   |  |
|   | 4a. Facility Name (if not institution, give street and number)  |  | 4b. City, Town, or Location of Death  |  | 4c. County of Death  |  |
|   | Southern Maryland Hospital  |  | Clinton   |  | Prince George's  |  |
| Funeral<br>Director   | 5. Social Security Number   |  | 6. Sex  |  | 7. Age (In yrs. last birthday)   |  |
|   | 048-24-2089   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                      |  | 81 Yrs.  |  |
|   | 8. Date of Birth (MM/DD/YYYY)   |  | 9. Birthplace (State or Foreign Country)  |  |  |  |
|   | Feb. 23, 1929   |  | South Carolina  |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10a. State  |  | 10b. County  |  |
|   | 10c. City, Town or Location   |  | 10d. Inside City Limits   |  |  |  |
|   | 10e. Street and Number  |  | 10f. Zip Code   |  | 10g. Citizen of What Country?  |  |
|   | 912 Hampton Avenue  |  | 29601   |  | USA  |  |
|   | 11. Marital Status  |  | 12. Was Decedent Ever in U.S. Armed Forces?   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |
|   | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:                             |  |
|   | 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | If Yes, Give Year or Dates:   |  | Specify: Black   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  | 16b. Kind of Business/Industry   |  |
|   | Elementary/Secondary (0-12) College (1-4 or 5+)   |  | Cook  |  | Private Industry   |  |
|   | 17. Father's Name (First, Middle, Last)   |  | 18. Mother's Name (First, Middle, Maiden Surname)   |  |  |  |
| Raleigh Harris  |   | Annie Hardy  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)             |  |  |  |
|   | Antonio Lunsford/Son  |  | 12305 Lusby's Lane<br>Brandywine, MD 20613  |  |  |  |
|   | 20a. Method of Disposition  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                    |  | 20c. Location - City or Town, State  |  |
|   | 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | Resthaven Memorial Gardens  |  | 2/19/11 Peidmont, SC   |  |
|   | 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility  |  |  |  |
|   | Phyllis A. Gordon M00969  |  | AGEE/McKinnon Funeral Service<br>3821 14th Street, N.W., Washington, DC 20011                             |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  | Approximate Interval Between Onset and Death  |  |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)   |  | a. End Stage Renal Disease  |  |  |  |
|   | Due to (or as a consequence of):  |  | b.  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last              |   | Due to (or as a consequence of):   |   |  |  |  |
| c.  |   | Due to (or as a consequence of):   |   |  |  |  |
| d.  |   |  |   |  |  |  |
| <input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED  |   |  |   |  |  |  |
| IF FEMALE:  |   | 23c. If yes, outcome of pregnancy  |   | 23d. Date of delivery  |  |  |
| 23b. Was decedent pregnant in the past 12 months?   |   | 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy  |   | Month Day Year   |  |  |
| 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)   |   | g <input type="checkbox"/> Unknown   |   |  |  |  |
| 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23e. Did tobacco use contribute to the cause of death?   |   | 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |   | 24a. Was an autopsy performed?   |   | 24b. Were autopsy findings available prior to completion of cause of death?  |  |  |
|   |   | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?  |   | 26. Place of Death (Check only one)  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |   |  |  |  |
| 27. Manner of Death   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury  |  |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |   |  |   | 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |   |  |   |  |  |  |
| 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|   |   |  |   |  |  |  |
| 29a. Certifier (Check only one)   |   | 29b. Signature and title of certifier  |   | 29c. License number  |  |  |
| 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                               |   | O.C.M.E.   |  |  |
|   |   | 29d. Date signed (Month, Day, Year)  |   | February 13, 2011  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a)  |   | 31. Date filed (Month, Day, Year)  |   | 32. Registrar's Signature  |  |  |
| Margarita Korell MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  |   | FEB 25 2011  |   | [Signature]  |  |  |
| State Registrar   |   |  |   |  |  |  |

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

H

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clifford A. Ludwig, Sr.

2. Date of Death

Month Day Year  
FEBRUARY 21, 2011

3. Time of Death

5:16P M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212 36 5295

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/24/1938

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2715 Norland Road

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Foreman

16b. Kind of Business Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Garland C. Ludwig

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Young

19a. Informant's Name/Relationship (Type, Print)

Rosemarie Ludwig / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2715 Norland Road Baltimore, Maryland 21230

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bayview Crematory

Date

02/28/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Service, P.A.  
4001 Ritchie Highway Baltimore, Maryland 21225Physician/  
Medical  
Examiner23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CARDIOMYOPATHY

Approximate  
Interval Between  
Onset and Death  
DAYSSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_\_  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST CORONARY BYPASS SURGERY

MORBID OBESITY

ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0060495

29d. Date signed (Month, Day, Year)

2/22/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZHEN FAN, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Deborah Lance

2. Date of Death

2 22 2011

3. Time of Death

9:20 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

218-46-5868

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

12/02/1946

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

19 NORTH HILTON STREET

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE WORKER

16b. Kind of Business Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

LEROY JOHNSON SR

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA BIRDSON Byrdsong

19a. Informant's Name/Relationship (Type, Print)

CARLOS LANCE / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 N. HILTON ST., BALTIMORE, MARYLAND 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST CEME.

Date

03/

02/2011

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

THE DERRICK C. JONES FH, P.A.  
21215  
4601 PARK HILLS AVE., BALTIMORE, MARYLAND

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition, foot ulcers

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Uni Wong MD

29c. License number

NPI 1043538069

29d. Date signed (Month, Day, Year)

2/22/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Uni Wong 22 S. Greene St, Baltimore MD 21201

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

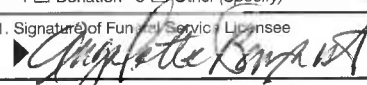
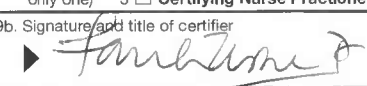

2011 05792

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Paul G. Larkin</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> , Year <b>2011</b>   |                                | 3. Time of Death<br><b>6:30 AM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |                                | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>168-20-5721</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>February 25, 1928</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>9407 Holland Avenue</b>  |  |   |  | 10f. Zip Code<br><b>20814</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>College Administration</b>   |                                | 16b. Kind of Business Industry<br><b>Community College</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph A. Larkin</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Briggman</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Amy Larkin / Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20852 5800 Nicholson Lane, Apt. L7, Rockville, Maryland</b>                                     |                                |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |  | Date <b>February 24, 2011</b>  |                                | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br> <b>M01305</b>  |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>                                       |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death   |  |   |  |  |                                |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute Renal Failure, Hypertension, Diabetes Mellitus II, Hyperlipidemia</b>  |  |   |  |  |                                | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |                                | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |  |
| 29a. Certifier<br>(Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D70395</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>2/18/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Farah Abdulsalam, MD 1500 Forest Glen Road, Silver Spring, Maryland 20910</b>  |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |   |  | 32. Registrar's Signature<br>   |                                |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2011 05793

1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Keith

Ledlow

2. Date of Death

February 17, 2011

3. Time of Death

0945 hrs

4a. Facility Name (if not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

218-62-3103

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55

8. Date of Birth (MM/DD/YYYY)

05 17 55

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3412 East Baltimore Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correctional Officer

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

James Earl Ledlow

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Rice

19a. Informant's Name/Relationship (Type, Print)

Jerry Ledlow-Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Idlewild Road, Belair, Md 21014

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State

☐ Donation ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

On-Site

Date

2/24/2011

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service License

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alprazolam intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED

☐ AMENDED

23a, 27, 28a-f, per ME g913 3/3/11 TT

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☐ No ☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy

☐ Pregnant at time of death ☐ Other (Specify)

☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA ☐ Other: ☐ Nursing Home ☐ Residence ☐ Other:

27. Manner of Death

☐ Natural ☐ Pending Investigation

☐ Accident ☒ Could not be determined

☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

fd 2/17/11

28b. Time of Injury

fd 9:05 am

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

unk

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3412 E. Baltimore St Baltimore, MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Carol Allan

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Keith Ledlow

17907  
Baltimore, MD 21215-0036  
Department of Health and Mental Hygiene  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

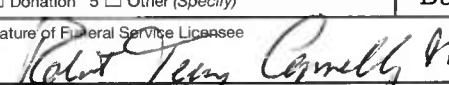
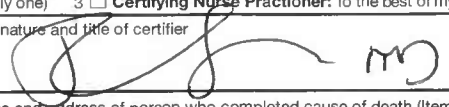

State of Maryland / Department of Health and Mental Hygiene

2011 05794

1- For State Amend Item 25 pr me, g912,02/25/2011 dbb  
Registrar Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |  |  |
|--|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Doris Alma Mueller</b>  |  | 2. Date of Death<br>Month <b>JANUARY</b> Day <b>24</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>2:20 A M</b>  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>SINAI HOSPITAL OF BALTIMORE</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |   | 4c. County of Death  |  |  |
| 5. Social Security Number<br><b>218-26-3715</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 29, 1927</b>               |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
| Usual Residence of Decedent  |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  | 10b. County  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>3612 Edmondson Avenue</b>   |  | 10f. Zip Code<br><b>21229</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |   |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>own home</b>   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jack Platt</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ina Pritchett</b> |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles Mueller /son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>562 Chalcot Square Essex MD 21221</b>   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory</b>  |   | 20c. Location - City or Town, State<br><b>1/26/2011 Baltimore MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>300 Mace Ave. Balto. MD<br/>Connelly Funeral Home of Essex 21221</b>   |   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>PULMONARY EMBOLISM</b>  |  |   |   |  | Approximate Interval Between Onset and Death   |  |
| 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CLOSTRIDIUM DIFFICILE COLITIS<br/>ACUTE KIDNEY INJURY</b>  |  |   |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  |   |   |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CLOSTRIDIUM DIFFICILE COLITIS<br/>ACUTE KIDNEY INJURY</b>   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br><b>M</b>   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D63430</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JANUARY 24 2011</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAVIT S. KHUNKHUN MD SINAI HOSPITAL OF BALTIMORE</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05795

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM BAKER MOSHER, JR.

2. Date of Death

Month February Day 24, Year 2011

3. Time of Death

9:30 A M

4a. Facility Name (if not institution, give street and number)

OAK CREST VILLAGE

4b. City, Town, or Location of Death

Parkville

4c. County of Death

Baltimore County

5. Social Security Number

714-05-5352

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

96

8. Date of Birth

If Under 1 Year Months Days If Under 24 Hrs. Hours Min.

8. Date of Birth

(Month, Day, Year) Nov 19, 1914

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8800 Walther Boulevard

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business Industry

Railway Trucking

17. Father's Name (First, Middle, Last)

William Baker Mosher, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Fredricka Ahrens

19a. Informant's Name/Relationship (Type, Print)

William A. Mosher (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18815 York Road, Parkton, MD 21120

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory

Date

2/26/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

MITCHELL-WIEDEFELD FUNERAL HOME, INC.

6500 York Road, Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Kidney Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner3 ☐ Certifying Nurse Practitioner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alice Brazier CRNP

29c. License number

MD# B067343

29d. Date signed (Month, Day, Year)

Feb 24, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alice BRAZIER 8800 Walther Blvd Parkville, MD 21234

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

James A. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05796

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Baby Boy Mohanasundaram</b>  |  |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>18</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>2:36 PM</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Shady Grove Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>INFANT</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>Yrs. <b>3</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 15, 2011</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |  |  |   |  |
| Usual Residence of Decedent   |  |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>6445 Rock Forest Dr; Apt 205</b>   |  |  |  | 10f. Zip Code<br><b>20817</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>indian</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>INFANT</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>INFANT</b>   |  | 16b. Kind of Business Industry<br><b>INFANT</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Kiran Kumaraswamy</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Srividhya Mohanasundaram</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Srividhya Mohanasundaram - mother</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6445 Rock Forest Dr Apt 205; Bethesda, MD 20817</b>                                      |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>In state</b>  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>State Anatomy Board</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD 21201</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  |  |  | 22. Name and Address of Facility<br><b>State Anatomy Board</b><br><b>655 W. Baltimore St; Baltimore, MD 21201</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory failure</b><br>Due to (or as a consequence of):<br><b>b. Hypoxic Ischemic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>c. Perinatal asphyxia</b><br>Due to (or as a consequence of):<br><b>d.</b>   |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>4 days</b><br><b>4 days</b> |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input checked="" type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypotension, hypotension, coagulopathy, oliguria</b><br><b>Hypocalcemia, cardiac arrest at birth, metabolic acidosis</b>   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)            |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M _____   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Dr. Kimberly Defallano</b>  |  |  |  | 29c. License number<br><b>D50902</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 18, 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A Kimberly Defallano, MD 9901 Medical Center Drive Rockville Maryland 20850</b>  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |

Mohanasundaram Boy  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05797

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary Jo Markaroff</b>   |  |  |  | 2. Date of Death<br>Month <b>February</b> Day <b>16</b> Year <b>2011</b>  |  |  |  | 3. Time of Death<br><b>8:55 P M</b>                                     |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>62 Drumcastle Court</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Germantown</b>   |  |  |  | 4c. County of Death<br><b>Montgomery</b>                                |  |  |  |
| 5. Social Security Number<br><b>210-28-9506</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 27, 1937</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>         |  |  |  |
| 10a. State<br><b>Maryland</b>  |  |  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Germantown</b>   |  |   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No              |  |
| 10e. Street and Number<br><b>62 Drumcastle Court</b>   |  |  |  | 10f. Zip Code<br><b>20876</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>              |  |  |  | 16b. Kind of Business/Industry<br><b>Healthcare</b>                     |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Szostek</b>   |  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Doroczky</b>   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph E. Markaroff/husband</b>   |  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>62 Drumcastle Court Germantown, Maryland 20876</b> |  |   |  |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Final Journey Crematory</b>  |  |  |  | Date<br><b>2/25/2011</b>  |  | 20c. Location - City or Town, State<br><b>Woodbine, Maryland</b> |  |
| 21. Signature of Funeral Service Licensee<br><b>Quantia R. Thomas</b>  |  |  |  | 22. Name and Address of Facility<br><b>M00957 Going Home Cremation Service P.O. Box 784<br/>Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>  |  |  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Gun shot chest</b><br>Due to (or as a consequence of):<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |   |  |  |  |   |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br><b>1</b> Yes <b>2</b> No<br><b>9</b> Unknown  |  |  |  |   |  |  |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br><b>1</b> Live birth <b>2</b> Fetal death <b>3</b> Ectopic pregnancy<br><b>4</b> Pregnant at time of death <b>5</b> Other (specify)<br><b>9</b> Unknown  |  |  |  |   |  |  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Schizophrenia</b>   |  |  |  |   |  |  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |  |  |   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  |  |  |   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |  |  |  |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  |  |  |   |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)   |  |  |  |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Feb 16 2011</b>  |  | 28b. Time of Injury<br><b>unk</b> M  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  | 28d. Describe how injury occurred<br><b>Self-inflicted GSW</b>   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>62 Drumcastle Ct Germantown, MD 20876</b>                      |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Sam B. Becker MD DOME</b>  |  |  |  | 29c. License number<br><b>D 00428</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>Feb 19 2011</b>               |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>IRB B. BRECKER, MD DOME 524 HAWKESBURY Ln Silver Spring MD 20904</b>  |  |  |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |  |  | 32. Registrar's Signature<br><b>Anna P. Spaul</b>   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Viola Mills</b>  |   | 2. Date of Death<br>Month <b>Feb</b> Day <b>17</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>6.30p</b> M   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>1100 Pennsylvania Avenue</b>   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-12-4497</b>   | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 8, 1924</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent   |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>1100 Pennsylvania Avenue</b>   |   | 10f. Zip Code<br><b>21217</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>   |  | 16b. Kind of Business Industry<br><b>Enoch Pratt Library</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Edward Smith</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Hudson</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Denise Cooper</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>754 East 36th Street Baltimore, Maryland 21218</b>  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation - 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  | Date<br><b>02/24/11</b>  | 20c. Location - City or Town, State<br><b>Lansdowne, Maryland</b>  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Service, P. A.<br/>1300 Eutaw Place Baltimore, Md 21217</b>   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>COPD</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D69869</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/22/11</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>29 South Penn Street Baltimore MD 21201</b>  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>2/24 FEB 25 2011</b>  |   | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05799

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN C MCCAIN

2. Date of Death

02 20 2011

3. Time of Death

11:15 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

217-62-1948

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/28/1953

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

37 S. PULASKI STREET

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECURITY OFFICER

16b. Kind of Business Industry

SECURITY

17. Father's Name (First, Middle, Last)

HENRY MCCAIN

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA THOMPSON

19a. Informant's Name/Relationship (Type, Print)

CHER MCCAIN / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2108 N. SMALLWOOD ST., BALTIMORE, MARYLAND

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY INC.

Date

02/26/2011

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

THE DERRICK C. JONES F/H, P.A. 4611 PARK HIGTS. AVE., BALTIMORE, MARYLAND

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. WITNESSED SEIZURE

Due to (or as a consequence of):

b. PROLONGED CARDIAC ARREST

Due to (or as a consequence of):

c. HYPoxic BRAIN INJURY

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

DAYS

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LONGSTANDING SEIZURE DISORDER

HYPERTENSION

STAGE IV CKD

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Geoffrey A Sheinfeld MD

29c. License number

D 66335

29d. Date signed (Month, Day, Year)

02/20/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey A Sheinfeld MD

22 SOUTH GREENE ST

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

BALTIMORE MD 21201

Geoffrey Sheinfeld, M.D.

#036599

(410) 328-2337 ext. 6415

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

Roberto

Macatuno

2. Date of Death  
Month Day Year  
February 14, 20113. Time of Death  
0325 hrsFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

219-25-7237

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (MM/DD/YYYY)

06 06 60

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2105 Larkhall Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Filipino

Specify: ~~White~~

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Forklift Operator

16b. Kind of Business/Industry

Home Depot Excel

17. Father's Name (First, Middle, Last)

Mamerto Macatuno

18. Mother's Name (First, Middle, Maiden Surname)

Eugenia Cuevas

19a. Informant's Name/Relationship (Type, Print)

Patricia Macatuno-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2115 Larkhall Road, Dundalk, Md 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Manilla North

Date

3/7/2011

20c. Location - City or Town, State

Manilla

Philippines

21. Signature of Funeral Service Licensee

*Donna C. [Signature]*

22. Name and Address of Facility

March F/H West

4300 Wabash Ave, Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☒ AMENDED

14 per fh g912 2-25-11 vt

23a, 27 per me g913 3-1-11 vt

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 14, 2011

30. Name and address of person who completed cause of death (Item 23a)

Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

*[Signature]*

ORIGINAL

17908

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05801

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Elaine Joan Makovska

2. Date of Death

February 21, 2011

3. Time of Death

1:40 pm

4a. Facility Name (if not institution, give street and number)

Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

304-42-5230

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

8. Date of Birth (Month, Day, Year)

3/24/1939

9. Birthplace (State or Foreign Country)

IN

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

107B N. Summit Ave #6

10f. Zip Code

20877

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Instructor

16b. Kind of Business Industry

College

17. Father's Name (First, Middle, Last)

Edmond F. Makowski

18. Mother's Name (First, Middle, Maiden Surname)

Victoria Mysliwiec

19a. Informant's Name/Relationship (Type, Print)

Barbara Waite-Jaques, executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12919 Falmouth Dr. Silver Spring, MD 20904

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, 2/24/2011 Beltsville, MD

Date

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

M00982

22. Name and Address of Facility

Rapp Funeral &amp; Cremation Svcs.

933 Gist Ave. Silver Spring, MD 20910

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. S/P Ileostomy Reversal with Post-Op

Due to (or as a consequence of):

days

c. Anastomotic Leak

Due to (or as a consequence of):

days

d. Sepsis

days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
g ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37142

29d. Date signed (Month, Day, Year)

2-21-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G Coleman MD; 6001 Muncaster Mill Road Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05802

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilbur Lloyd Mills Sr.

2. Date of Death

Feb 19 2011

3. Time of Death

14:56 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

220-36-3511

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

8. Date of Birth (Month, Day, Year)

12/18/1937

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 N. Wheeler Ave.

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Hajoca Corp.

17. Father's Name (First, Middle, Last)

John Royster

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Mills

19a. Informant's Name/Relationship (Type, Print)

Joyce Mills(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 N. Wheeler Ave., Baltimore, MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral

Date

02/24/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Joseph H. Brown Jr. Funeral Home PA

22. Name and Address of Facility

2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Renal Failure  
Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

P-24064

29d. Date signed (Month, Day, Year)

2/19/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2AR 2AR PE, 900, Calton Avenue, Baltimore, MD-21229

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Linda B. Parks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Mills, Wilbur



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05803

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

JUSTIN PENWELL NUSZ

2. Date of Death

February 21, 2011

3. Time of Death

1013 hrs

4a. Facility Name (if not institution, give street and number)

South Lake Court &amp; South Lake Way

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore County

5. Social Security Number

214-15-8944

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

28

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

05/07/1982

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Seiler Court

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Server

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

William Penwell Nusz

18. Mother's Name (First, Middle, Maiden Surname)

Susan Lynne Leventhall

19a. Informant's Name/Relationship (Type, Print)

William Penwell Nusz

Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10700 Cardington Way #101 Cockeysville MD 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory

Date

02/24/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*James Seiler Nusz*

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury

Feb 21, 2011

28b. Time of Injury

1013 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Wooded area

28f. Location (Street and Number or Rural Route Number, City or Town, State)

South Lake Court &amp; South Lake Way, Reisterstown, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Carol Allan*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 22, 2011

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

*James Seiler Nusz*

ORIGINAL

OCME

Baltimore, MD 21215-0036

Physician  
/M.  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05804

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |  |  |                                   |  |
|---|---|--|---|--|---|--|--|--|--|--|-----------------------------------|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>James Robert Neff   |  |   |  | 2. Date of Death<br>Month February Day 21, Year 2011  |  |  |  | 3. Time of Death<br>3:30 P.M.  |  |                                   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br>7466 E. Furnace Branch Road Apt. 205  |  |   |  | 4b. City, Town, or Location of Death<br>Glen Burnie   |  |  |  | 4c. County of Death<br>Anne Arundel  |  |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>212 42 3728  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>64 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>03/05/1946                  |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |                                   |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |  |  |  |                                   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Glen Burnie  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                   |  |
|   | 10e. Street and Number<br>7466 E. Furnace Branch Road Apt. 205  |  |   |  | 10f. Zip Code<br>21060  |  |  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |                                   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Custodian  |  |  |  | 16b. Kind of Business Industry<br>Anne Arundel Co. School System   |  |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Francis G. Neff  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Agnes Johnson |  |  |  |                                   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy Spacek / Sister   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>300 - 10th Avenue Baltimore, Maryland 21225  |  |  |  |  |  |                                   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Cross Cemetery   |  | Date<br>02/25/2010   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Anna Znamionouski</i>   |  |   |  | 22. Name and Address of Facility<br>Gonce Funeral Service, P.A.<br>4001 Ritchie Highway Baltimore, Maryland 21225   |  |  |  |  |  |                                   |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. RESTRICTIVE AIRWAY DISEASE<br>Due to (or as a consequence of):<br>b. MORBID OBESITY<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.  |  |   |  |   |  |  |  |  |  |                                   |  |
|   | Approximate Interval Between Onset and Death<br>Lifetime  |  |   |  |   |  |  |  |  |  |                                   |  |
| To Be Completed by Physician/Medical Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |  |  |                                   |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)   |  |   |  |   |  |  |  |  |  |                                   |  |
|   | 23d. Date of delivery<br>Month Day Year   |  |   |  |   |  |  |  |  |  |                                   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CORONARY ARTERY DISEASE   |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                   |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |                                   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |                                   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |                                   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |  |  |                                   |  |
|   | 29b. Signature and title of certifier<br><i>Richard E. Fisher</i>   |  |   |  | 29c. License number<br>D0002519   |  |  |  | 29d. Date signed (Month, Day, Year)<br>FEB 23, 2011  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard Fisher MD CRAN TOWERS, GLEN BURNIE MD 21061 |   |  |   |  |   |  |  |  |  |  |                                   |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>FEB 25 2011  |  |   |  | 32. Registrar's Signature<br><i>Anna A. Gave</i>  |  |  |  |  |  |                                   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

5v

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05805

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome Lamont Owens

2. Date of Death

Month 2 Day 18 Year 2011

3. Time of Death

21:54 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Upper Chesapeake Hospital

4b. City, Town, or Location of Death

Belair

4c. County of Death

Harford

5. Social Security Number

214-54-2502

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 10-26-1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Belair

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1204 Saddleback Way

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th gradeCollege (1-4 or 5+)  
Doctorate Degree16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Minister

16b. Kind of Business Industry

Church

17. Father's Name (First, Middle, Last)

Wiley Melvin Owens

18. Mother's Name (First, Middle, Maiden Surname)

Louise Hicks

19a. Informant's Name/Relationship (Type, Print)

Dr. Melva Owens-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1204 Saddleback Way Belair, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley

Date

2-24-2011

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Joseph R. Walters Jr

22. Name and Address of Facility

March East F/H

1101 E. North Avenue Balto, MD 21202

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute Pontine Infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
unknownSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Subdural hematomas  
Due to (or as a consequence of):

unknown

c. Metastatic Prostate Cancer  
Due to (or as a consequence of):

unknown

d. Pancytopenia

unknown

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute respiratory failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D0065421

29d. Date signed (Month, Day, Year)

February, 18, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christa R. Fisher, MD 500 Upper Chesapeake Drive, Bel Air, MD 21014

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Ann S. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

#23apt-I fax to Dr. Owens, Jerome, M.D. DOD: 2/18/11 TOD: 2154

Division of Vital Records, P.O. Box 68760

15+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05806

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ronald David Orr

2. Date of Death

Month Day Year  
February 19, 2011

3. Time of Death

12:52 P M

4a. Facility Name (if not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

316-44-0014

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 27, 1944

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15713 Mahogany Circle #105

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Systems Analyst

16b. Kind of Business Industry

Computer Technology

17. Father's Name (First, Middle, Last)

Oron James Orr

18. Mother's Name (First, Middle, Maiden Surname)

Irma Ruth McCarroll

19a. Informant's Name/Relationship (Type, Print)

Connie E. Orr/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15713 Mahogany Circle #105 Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 2/23/2011

Date

20c. Location - City or Town, State

Woodbine, Maryland

21. Signature of Funeral Service Licensee

Juanita R Thomas

M00957

22. Name and Address of Facility

Going Home Cremation Service P.O. Box 734  
Beverly L. Heckrotte, P.A. Clarksville, MD 21029

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute pneumococcal sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. chronic myeloma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Wallmark M.D.

29c. License number

S3177

29d. Date signed (Month, Day, Year)

February 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Wallmark, MD 9707 Medical Center Drive, Suite 300 Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

James A. Spivey

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0036  
permitted. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05807

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ada Oursler

2. Date of Death

Month Day Year  
FEB. 23, 2011

3. Time of Death

2:25p M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Fair Haven

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

5. Social Security Number

007-20-2524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 11, 1921

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 Third Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☒ Yes 2 ☐ No WWII

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Claims Examiner

16b. Kind of Business Industry

Federal Government

17. Father's Name (First, Middle, Last)

Arthur Pressey

18. Mother's Name (First, Middle, Maiden Surname)

Annie Goodwin

19a. Informant's Name/Relationship (Type, Print)

Sandra Horichs/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

825 Western Chapel Road Wesminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation Service

Date

2/25/2011

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Sandra McDonald

22. Name and Address of Facility

Haight Funeral Home & Chapel, P.A.  
P.O. Box 195 Sykesville, MD 21784 (410-795-1400)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Actual Libellation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be determined  
4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

William Tan MD

29c. License number

D34849

29d. Date signed (Month, Day, Year)

February 24 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Tan MD 1645 Liberty Rd E lbersburg MD 21784

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Sandra A. Spaw

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05808

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>GLORIA OMINSKY</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>20</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>8:40 A M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>MILFORD MANOR NURSING HOME</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>214-30-4998</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>03/29/1933</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>OWINGS MILLS</b>   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>4730 ATRIUM COURT, UNIT 460</b>  |  | 10f. Zip Code<br><b>21117</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE</b>   |  | 16b. Kind of Business Industry<br><b>NURSING</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>LOUIS OMINSKY</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MOLLIE GUILFORD</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MICHAEL HODES/ATTORNEY</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>901 DULANEY VALLEY RD, SUITE 400, TOWSON, MD 21204</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON CHIZUK AMONO CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>02/22/2011 BALTIMORE, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ENDOMETRIAL CANCER</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last          |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                    |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>00057465</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/24/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N. S. RAJAPAKSE, M.D. 2835 SMITH AV. 5-203, BALTIMORE, MD 21209.</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



1- For Amend Items 23a-f, 25, 27, 28a-f per me, g912, 02/25/2011 and

2011 05809

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>SANDRA E. PERRY</b>   |  | 2. Date of Death<br>Month <b>January</b> Day <b>4</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>11:45P</b> M  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>FutureCare Cherrywood</b>   |  | 4b. City, Town, or Location of Death<br><b>REISTERSTOWN</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>317-38-3414</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>5/30/38</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>REISTERSTOWN</b>   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |
| 10e. Street and Number<br><b>12020 REISTERSTOWN Rd.</b>  |  | 10f. Zip Code<br><b>21136</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>housekeeper</b>   |   | 16b. Kind of Business Industry<br><b>hospitality</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Talbot Davenport</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eileen Davenport</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Terry Sullivan - guardian</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 N. Calvert St; Baltimore, Maryland 21202</b> |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |   | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald S. Wade, Director</b>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board<br/>655 W. Baltimore St; Baltimore, MD 21201</b>   |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Subdural Hematoma</b>  |  |   |   |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Encephalopathy</b>   |  |   |   |  | <b>16 MONTHS</b>   |
| Due to (or as a consequence of):<br><b>Subdural Hematoma Fall</b>  |  |   |   |  |  |
| Due to (or as a consequence of):<br><b>Cardiac Arrest</b>  |  |   |   |  |  |
| Due to (or as a consequence of):   |  |   |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Respiratory Failure</b>   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)<br><b>07/2009</b>  |   | 28b. Time of injury<br><b>Unknown</b> M  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Fall</b>  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Hospital</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Spring Grove Hosp.<br/>55 Wade Ave, Catonsville, MD, 21228</b>   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>DR. CAROL HALL</b>   |  | 29c. License number<br><b>RO88852</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>January 12 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KENNETH C. DIAMOND 2835 Smith Avenue, Baltimore, Maryland 21209</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br><b>James A. Spaw</b>   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760



# VOID

Sandra Perry

certificate no.: 2011 - 05810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05811

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Irene Postles

2. Date of Death

February 22 2011

3. Time of Death

1240A M

4a. Facility Name (If not institution, give street and number)

Copper Ridge

4b. City, Town, or Location of Death

Sykesville

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

145-24-5947

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/28/1931

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Md.

10b. County

Carroll

10c. City, Town or Location

Taneytown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

160 Carnival Drive

10f. Zip Code

21787

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12Yrs.

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

New York City  
Board Of Education

17. Father's Name (First, Middle, Last)

Edward R. Postles

18. Mother's Name (First, Middle, Maiden Surname)

Julia Emma Louise Harris

19a. Informant's Name/Relationship (Type, Print)

Andrea Postles ( Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Mike Court Elkton, Md. 21921.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

All County Cremation

Date

02/23/2011

20c. Location - City or Town, State

Sykesville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville, Md. 21784.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

paroxysmal atrial tachycardia  
aortic aneurysm

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D67296

29d. Date signed (Month, Day, Year)

02/22/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gloria D. Fulk MD Copper Ridge

710 Obrecht Road Sykesville, MD 21784

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05812

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Martha Parrish</b>   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Feb 15, 2011</b>      |   | 3. Time of Death<br><b>9:00a</b> M  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Future Care—Old Court</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |  | 4c. County of Death<br><b>Baltimore</b>                        |   |   |  |
| 5. Social Security Number<br><b>212-26-8092</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 24, 1913</b>     |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |
| Usual Residence of Decedent   |  |   |  |   |  |  |   |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>3342 Mondawmin Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                 |   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Private Homes</b>                  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ezra Hamlett</b>  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marcella Hamlett</b> |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Parrish</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>500 Marley Neck Boulevard Glen Burnie, Maryland 21060</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Park Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b> |   | 20d. Date<br><b>02/22/11</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Service, P. A.<br/>1300 Eutaw Place Baltimore, Md 21217</b>   |  |  |   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. <b>Type II Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b> |  |   |  |   |  |  |   |   |  |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |  |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Kidney Disease Stage IV</b>  |  |   |  |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                                       |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D32158</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/21/11</b>          |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jyoti Parikh, MD 821 N. Eutaw St, Ste 407, Baltimore, MD 21201</b>   |  |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05813

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GARRETT JACKSON PHILLIPS

2. Date of Death

Month Day Year  
February 17 2011

3. Time of Death

6:20 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

219-26-1462

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/24/1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1705 E. Eager St. Apt 212

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sterilization Tech

16b. Kind of Business Industry

John Hopkins

17. Father's Name (First, Middle, Last)

Preston Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Bertha unk

19a. Informant's Name/Relationship (Type, Print)

Jacqueline Phillips(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 E. Eager St. Apt 212, Baltimore, MD 21205

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

on-site Crematory

Date

02/25/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Joseph H. Brown Jr. Funeral Home PA

22. Name and Address of Facility

2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. PNEUMONIA  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Unknown

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. COPD  
Due to (or as a consequence of):

Unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

M

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

RES-001

February 17, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raquel Silva 3001 South Harbor Street Baltimore, MD 21225

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Benjamin A. Spaw

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05814

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ashley Reese

2. Date of Death

02 18 2011

3. Time of Death

7:05p M

4a. Facility Name (If not institution, give street and number)

Joseph Ritchie

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-78-5651

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/19/1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

838 N. Eutaw St.

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business Industry

N/A

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Emily Reese

19a. Informant's Name/Relationship (Type, Print)

Tanya Young(cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2809 Jefferson St., Baltimore, MD 21205

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

on-site Crematory

Date

02/23/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Joseph H. Brown Jr. Funeral Home PA

22. Name and Address of Facility

2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic adenocarcinoma, unknown origin

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hypotension secondary to adrenal crisis

Due to (or as a consequence of):

3 mos.

c. Craniopharyngioma

Due to (or as a consequence of):

unknown

d. diabetes insipidus

unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Epilepsy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Hospice house

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Camille Menino, CRNP

29c. License number

R107936

29d. Date signed (Month, Day, Year)

February 19, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Camille Menino, CRNP Joseph Richey Hospice, 828 N. Eutaw St, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 23 2011

32. Registrar's Signature

Denise A. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitAshley A. Reese 2/18/2011 @ 7:05 PM  
Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05815

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Issac Lee Strother

2. Date of Death

Month 2 Day 17 Year 2011

3. Time of Death

9:03 pM

4a. Facility Name (if not institution, give street and number)

Northwest Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

229-34-3047

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10-02-1931

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

na

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4601 Pall Mall Road

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business Industry

Painting

17. Father's Name (First, Middle, Last)

Mitchell Strother

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Johnson

19a. Informant's Name/Relationship (Type, Print)

Brother

Fillmore Strother -

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4085 S. Blueridge Turnpike Rochelle, VA

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Johnson s Cremat

Date

2-26-2011

20c. Location - City or Town, State

Locust Grove, VA

21. Signature of Funeral Service Licensee

Alyette K. Jones

22. Name and Address of Facility Satchell F/H

118 E. Church Street Orange, VA 22960

23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

10 Yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael K. Jones

29c. License number

031861

29d. Date signed (Month, Day, Year)

2/24/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael - Jones / Krong Rm 206 821 N Lintwood Blvd

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Michael K. Jones

ma 2/25/11

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerDivision of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL



**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
State of Maryland / Department of Health and Mental Hygiene  
**Certificate of Death**

2011 05816

1- For State  
Registrar

Reg. No.

**Physician/  
Medical Examiner**

|   |  |  |                                     |
|---|--|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Julius Smith</b> |  | 2. Date of Death<br>Month <b>February</b> Day <b>22</b> Year <b>2011</b> | 3. Time of Death<br><b>1325 hrs</b> |
|---|--|--|-------------------------------------|

**Funeral  
Director**

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| 4a. Facility Name (if not institution, give street and number)<br><b>Johns Hopkins Hospital</b> |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |   | 4c. County of Death                               |   |
| 5. Social Security Number<br><b>220-62-0706</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.         | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>3-13-1956</b> | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b> |

|                             |                          |   |  |
|-----------------------------|--------------------------|---|--|
| Usual Residence of Decedent |                          |   |  |
| 10a. State<br><b>MD</b>     | 10b. County<br><b>na</b> | 10c. City, Town or Location<br><b>Baltimore</b> | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

|  |  |                               |   |
|--|--|-------------------------------|---|
| 10e. Street and Number<br><b>1816 E. 28th Street</b> |  | 10f. Zip Code<br><b>21218</b> | 10g. Citizen of What Country?<br><b>USA</b> |
|--|--|-------------------------------|---|

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Back</b> |  |
|--|--|---|--|--|--|--|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborered</b> |  | 16b. Kind of Business/Industry<br><b>Varoius Jobs</b> |  |
|--|--|---|--|---|--|

|   |  |   |  |
|---|--|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Cornelius Smith, Sr</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esther Mae Fisher</b> |  |
|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print) <b>Brother</b><br><b>Cornelius Smith, Jr-</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3003 Kenyon Avenue Balto, MD 21213</b> |  |
|--|--|--|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify: |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Pk</b> |  | 20c. Location - City or Town, State<br><b>2-28-2011 Randallstown, MD</b> |  |
|--|--|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> |  | 22. Name and Address of Facility<br><b>March East F/H</b><br><b>1101 E. North Avenue Balto, MD 21213</b> |  |
|---|--|--|--|

|  |  |  |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <b>Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death |
|--|--|--|

|  |  |  |
|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death |
|--|--|--|

|                                     |  |  |
|-------------------------------------|--|--|
| c. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death |
|-------------------------------------|--|--|

|                                     |  |  |
|-------------------------------------|--|--|
| d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death |
|-------------------------------------|--|--|

|  |   |
|--|---|
| <input checked="" type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED <b>23a,27 per me g914 4-21-11 vt</b> |
|--|---|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
|--|--|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|--|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|---|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other: |  |  |  |
|---|--|--|--|--|--|

|   |  |  |  |                     |  |  |  |                                   |  |
|---|--|--|--|---------------------|--|--|--|-----------------------------------|--|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|---|--|--|--|---------------------|--|--|--|-----------------------------------|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
|--|--|--|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |
|---|--|--|--|--|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 29b. Signature and title of certifier<br><i>[Signature]</i> |  | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>February 23, 2011</b> |  |
|---|--|--|--|---|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |  |  |  |  |  |
|--|--|--|--|--|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 31. Date filed (Month, Day, Year) <b>FEB 25 2011</b> |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |  |  |
|--|--|---|--|--|--|

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036**  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
**Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Terry Sellers

2. Date of Death

Month Day Year  
February 23, 2011

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Blue Point Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

218-46-5597

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 18, 1947

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

121 Forestdale Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1966-69

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th grade

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John M. Sellers

18. Mother's Name (First, Middle, Maiden Surname)

Florence Ray

19a. Informant's Name/Relationship (Type, Print)

Kathy Jones / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

121 Forestdale Avenue, Glen Burnie, MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory INC

Date

02-25-2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*Patrik Flaning*

Patrik Flaning

22. Name and Address of Facility

Cremation Society of Maryland INC

299 Frederick Road, Baltimore, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions,

if only leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Harold B. Chen, MD*

29c. License number

21680

29d. Date signed (Month, Day, Year)

2/25/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6717 Park Heights Ave. - Balto, MD - 21215

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

*James A. Jones*

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, &amp;

2+1

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

## Certificate of Death

1- For  
State  
Registrar

2011 05818

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANE

2. Date of Death

February 22, 2011

3. Time of Death

14:34 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

091-36-3782

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

8. Date of Birth

May 5, 1945

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8175 Baltimore National Pike

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clinical Social Worker

16b. Kind of Business/Industry

Private Practice

17. Father's Name (First, Middle, Last)

Theodore B. Steinhausen

18. Mother's Name (First, Middle, Maiden Surname)

Jane Wolcott

19a. Informant's Name/Relationship (Type, Print)

Charles J. Semich/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8175 Baltimore National Pike, Ellicott City MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, INC 02-24-2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Patrik Fleming

22. Name and Address of Facility

Cremation Society Of Maryland INC  
299 Frederick Road, Baltimore, MD 21228

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Glioblastoma Multiforme

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Henry Brem MD

29c. License number

D24362

29d. Date signed (Month, Day, Year)

February 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HENRY BREM, MD Meyer 7-113 Johns Hopkins Hospital 600 W. Wolfe St Baltimore, MD 21287

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

S. S. S.

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
State of Maryland / Department of Health and Mental Hygiene  
*Certificate of Death*

2011 05819

1- For State  
Registrar

Reg. No.

**Physician/  
Medical Examiner**

|  |  |  |                                     |
|--|--|--|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ashley Nicole Stewart</b> |  | 2. Date of Death<br>Month <b>February</b> Day <b>15</b> Year <b>2011</b> | 3. Time of Death<br><b>0440 hrs</b> |
|--|--|--|-------------------------------------|

**Funeral  
Director**

|  |  |  |                     |
|--|--|--|---------------------|
| 4a. Facility Name (if not institution, give street and number)<br><b>University Hospital STU</b> |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> | 4c. County of Death |
|--|--|--|---------------------|

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| 5. Social Security Number<br><b>218-37-6065</b> | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>18</b> Yrs. | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (MM/DD/YYYY)<br><b>12-09-1992</b> | 9. Birthplace (State or Foreign Country) <b>MD</b> |
|---|--|--|---|--|--|

Usual Residence of Decedent

|                         |                               |   |  |
|-------------------------|-------------------------------|---|--|
| 10a. State<br><b>MD</b> | 10b. County<br><b>Harford</b> | 10c. City, Town or Location<br><b>Jarrettsville</b> | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|-------------------------|-------------------------------|---|--|

|   |  |                               |   |
|---|--|-------------------------------|---|
| 10e. Street and Number<br><b>1363 Wiley Oak Drive</b> |  | 10f. Zip Code<br><b>21084</b> | 10g. Citizen of What Country?<br><b>USA</b> |
|---|--|-------------------------------|---|

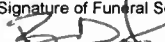
|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|--|--|---|--|--|--|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b> |  | 16b. Kind of Business/Industry<br><b>College</b> |  |
|---|--|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 17. Father's Name (First, Middle, Last)<br><b>William P. Stewart</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Karen A. Carlyle</b> |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen A. Stewart (Mother)</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1363 Wiley Oak Drive Jarrettsville, MD 21084</b> |  |
|--|--|--|--|

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highview Mem. Gardens</b> |  | 20c. Location - City or Town, State<br><b>02-19-2011 Fallston, MD</b> |  |
|--|--|--|--|---|--|

|  |  |   |  |
|--|--|---|--|
| 21. Signature of Funeral Service Licensee<br> |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of BelAir<br/>Inc 610 W. MacPhail Rd BelAir, MD 21014</b> |  |
|--|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Multiple Injuries</b><br>Due to (or as a consequence of):  |  |  |  |

|  |  |  |  |
|--|--|--|--|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  | Approximate Interval Between Onset and Death |
| b. Due to (or as a consequence of):  |  |  |  |

|                                     |  |  |  |
|-------------------------------------|--|--|--|
| c. Due to (or as a consequence of): |  |  | Approximate Interval Between Onset and Death |
| d. Due to (or as a consequence of): |  |  |  |

|                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> UNPENDED | <input type="checkbox"/> AMENDED |
|-----------------------------------|----------------------------------|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year |  |
|---|--|---|--|---|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|--|--|--|--|


|   |  |  |  |
|---|--|--|--|
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|---|--|--|--|

|   |  |  |  |
|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |  |
|---|--|--|--|

|   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)<br><b>Feb 14, 2011</b> |  | 28b. Time of Injury<br><b>1330 hrs</b> |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>Passenger of car injured in head on car car collision</b> |  |
|---|--|---|--|--|--|---|--|---|--|

|   |  |  |  |
|---|--|--|--|
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Major Road / Highway</b> |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Grier Nursery Road &amp; Millers Road, Norrisville, Md.</b> |  |
|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
|--|--|--|--|

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 29b. Signature and title of certifier<br><br><b>Zabiullah Ali, M.D. Assistant Medical Examiner</b> |  | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>February 16, 2011</b> |  |
|---|--|--|--|---|--|

|  |  |
|--|--|
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b> |  |
|--|--|

|   |  |  |  |
|---|--|--|--|
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b> |  | 32. Registrar's Signature<br> |  |
|---|--|--|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05820

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|   |                                 |  |  |  |
|---|---------------------------------|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kem Elwell Snow</b>  |                                 | 2. Date of Death<br>Month <b>February</b> Day <b>23</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>2:36 A M</b>  |
| 4a. Facility Name (if not institution, give street and number)<br><b>1002 Midvale Avenue</b>  |                                 | 4b. City, Town, or Location of Death<br><b>Mt. Airy</b>  |  | 4c. County of Death<br><b>Frederick</b>  |
| 5. Social Security Number<br><b>215-54-9848</b>   | 6. Sex<br><b>1 M 2 F</b>        | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 31, 1960</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent   |                                 |  |  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Frederick</b> | 10c. City, Town or Location<br><b>Mt. Airy</b>   |  | 10d. Inside City Limits<br><b>X Yes 2 No</b>   |
| 10e. Street and Number<br><b>1002 Midvale Avenue</b>  |                                 | 10f. Zip Code<br><b>21771</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |
| 11. Marital Status<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 X No</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 X No Specify:</b> |
| 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>   |                                 | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 2 College (1-4 or 5+)</b>                          |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Builder</b>   |                                 | 16b. Kind of Business Industry<br><b>Construction</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Edmond Snow</b>  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Inez Shirley Hobbs</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Caroline Snow/wife</b>   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1002 Midvale Avenue Mt. Airy, Maryland 21771</b> |  |  |
| 20a. Method of Disposition<br><b>1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Final Journey Crematory</b>   |  | 20c. Location - City or Town, State<br><b>2/26/2011 Woodbine, Maryland</b>   |
| 21. Signature of Funeral Service Licensee<br><b>Quanita R Thomas</b>  |                                 | 22. Name and Address of Facility<br><b>Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Non Small Cell Lung Cancer</b>   |                                 |  |  |  |
| 23b. Immediate Cause (Final disease or condition resulting in death)<br><b>Due to (or as a consequence of):</b>   |                                 |  |  |  |
| 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b>  |                                 |  |  |  |
| 23d. Date of delivery<br>Month Day Year   |                                 |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br><b>1 X Yes 2 No 3 Probably 4 Unknown</b>  |                                 |  |  |  |
| 23f. Was an autopsy performed?<br><b>1 Yes 2 X No</b>   |                                 |  |  |  |
| 23g. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>  |                                 |  |  |  |
| 24. Was case referred to medical examiner?<br><b>1 Yes 2 X No</b>   |                                 |  |  |  |
| 25. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 X Residence 6 Other (Specify)</b>  |                                 |  |  |  |
| 26. Manner of Death<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |                                 |  |  |  |
| 27. Date of injury (Month, Day, Year)<br><b>28a. Time of injury M 28b. Injury at work? 1 Yes 2 No</b>   |                                 |  |  |  |
| 28c. Describe how injury occurred<br><b>28d. Location (Street and Number or Rural Route Number, City or Town, State)</b>  |                                 |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                                 |  |  |  |
| 29b. Signature and title of certifier<br><b>Paul Bannen M.D.</b>  |                                 | 29c. License number<br><b>MD060335</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 23, 2011</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul A. Bannen, M.D. 1811 Prince Philip Dr. #327 Olney, Maryland 20832</b>   |                                 |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |                                 | 32. Registrar's Signature<br><b>Debra A. Sparks</b>  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

DHMH 17 Rev 7/2009

ORIGINAL

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |   |  |
|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Edward Raymond Shaw</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>19</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>09:35 A<sup>M</sup></b>   |
| 4a. Facility Name (if not institution, give street and number)<br><b>2752 Parallel Path</b>  |  | 4b. City, Town, or Location of Death<br><b>Abingdon</b>  |   | 4c. County of Death<br><b>Harford</b>  |
| 5. Social Security Number<br><b>174-42-4693</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 27, 1951</b> |  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |   |  |
| Usual Residence of Decedent  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Harford</b>  | 10c. City, Town or Location<br><b>Abingdon</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>2752 Parallel Path</b>  |  | 10f. Zip Code<br><b>21009</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Inspector</b>   |  | 16b. Kind of Business Industry<br><b>Real Estate</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Charles Shaw</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mildred Jane Lawson</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon Shaw / Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2752 Parallel Path, Abingdon, Maryland 21009</b>   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>H.G. Smith Crematory</b>  |   | 20c. Location - City or Town, State<br><b>Stroudsburg, PA</b>  |
| 21. Signature of Funeral Service licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Esophageal cancer</b>   |  |  |   | Approximate Interval Between Onset and Death   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)  |   | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of injury<br><b>M</b>                             | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD   |  | 29c. License number<br><b>DS6979</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2-20-2011</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Madai Chardon 417 Stemmers Run RD, Baltimore, MD 21221</b>  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05822

1- For State Registrar

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA P. SITARAS

2. Date of Death

Month

Day

Year

2-19-11

3. Time of Death

7:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MANOR CARE DULANEY

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

125-10-6514

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

8. Date of Birth (Month, Day, Year)

12/4/1917

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALDWIN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13805 MANOR GLEN ROAD

10f. Zip Code

21013

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

PETER MARGARITIS

18. Mother's Name (First, Middle, Maiden Surname)

ANASTASIA CHIADIS

19a. Informant's Name/Relationship (Type, Print)

CLEANTHE COCOROS/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13805 MANOR GLEN ROAD BALDWIN, MD 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONAL

Date

2/23/2011

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

MOO217

CEMETERY

22. Name and Address of Facility

THE JOHNSON FUNERAL HOME, P.A.

8521 LOCH RAVEN BLVD. TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Back Pain

Due to (or as a consequence of):

b. Osteoporosis

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month

Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H0054424

29d. Date signed (Month, Day, Year)

2-21-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cyrus Asadi, 3029 Dundalk Ave Dundalk, MD 21222

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

John A. Spake

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia R. Stencil

2. Date of Death

Feb 21 2011

3. Time of Death

1403 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Univ of MD Medical Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-56-0850

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 5, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

824 Fernhill Road

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business Industry

B G E

17. Father's Name (First, Middle, Last)

James

G.

Joyce

18. Mother's Name (First, Middle, Maiden Surname)

Lorraine

E.

Dorsey

19a. Informant's Name/Relationship (Type, Print)

Vernon J. Stencil (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

824 Fernhill Road Baltimore, Maryland 21226

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Gardens of Faith Cem. 02/25/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.  
3204 Mountain Road Pasadena, Maryland 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Septic Shock

b. Due to (or as a consequence of):

R Adrenal Abscess

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Resident Physician

29c. License number

P25726

29d. Date signed (Month, Day, Year)

Feb 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Su MD 22 S. Greene St. Baltimore MD

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For State Registrar

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Esther Claire Smith

2. Date of Death  
Month Day Year

02 19

2011

3. Time of Death  
M

7:47A

4a. Facility Name (If not institution, give street and number)

Future Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-16-9978

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth (Month, Day, Year)

10/16/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2307 Ashburton St.

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Microfilm

16b. Kind of Business/Industry

Gas &amp; Electric

17. Father's Name (First, Middle, Last)

John Bayton

18. Mother's Name (First, Middle, Maiden Surname)

Lagreta Taylor

19a. Informant's Name/Relationship (Type, Print)

Margaret Cunnunham (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3534 Carriage Hill Circle T2, Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Cem.

Date

03/01/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Joseph H. Brown Jr. Funeral Home PA

22. Name and Address of Facility

2140 N. Fulton Ave., Baltimore, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Thrombotic heart disease*  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
7 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Sweet's disease*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Karen W. McNeill

29c. License number

00043375

29d. Date signed (Month, Day, Year)

2/21/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN W. McNeill 2835 Smith Ave Suite 203 Baltimore, MD 21209

31. Date filed (Month, Day, Year)

FEB 24 2011

32. Registrar's Signature

Karen A. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 05825

Physician/  
Medical Examiner

Funeral  
Director

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any  
injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |
|---|--|--|--|
| 1. For State Registrar  |  | Reg. No.   |  |
| 1. Decedent's Name (First, Middle, Last)<br><b>Nyzirah Angel Smallwood</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>17</b> Year <b>2011</b>   | 3. Time of Death<br><b>0028 hrs</b>                |
| 4a. Facility Name (if not institution, give street and number)<br><b>Saint Agnes Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   | 4c. County of Death<br><b>N/A</b>                  |
| 5. Social Security Number<br><b>unk</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. <b>00</b> Mo <b>30</b> Days <b>00</b> Hours <b>30</b> Min.  | 8. Date of Birth (MM/DD/YYYY)<br><b>01/19/2011</b> |
| 9. Birthplace (State or Foreign Country) <b>MD</b>  |  | 10. Usual Residence of Decedent  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1934 W. Fayette St.</b>   |  |
| 10f. Zip Code<br><b>21223</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>  |  |
| 16b. Kind of Business/Industry<br><b>N/A</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Antonia Smallwood</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Erica Callaway</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Erica Callaway (mother)</b>   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1934 W. Fayette St., Baltimore, MD 21223</b>  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>on-site Crematory</b>  |  | 20c. Date<br><b>02/27/11</b>   |  |
| 20d. Location - City or Town, State<br><b>Baltimore, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><i>Joseph H. Brown Jr.</i>  |  |
| 22. Name and Address of Facility<br><b>Joseph H. Brown Jr. Funeral Home PA<br/>2140 N. Fulton Ave., Baltimore, MD 21217</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Complications of Prematurity</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  |
| 23d. Date of delivery<br>Month <b>February</b> Day <b>17</b> Year <b>2011</b>   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>February 17, 2011</b>   |  |
| 28b. Time of Injury<br><b>0030</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred<br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Pamela E. Southall, MD</i>   |  |
| 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 18, 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |
| 32. Registrar's Signature<br><i>Anna A. Parker</i>  |  | 33. Registrar's Title<br><b>Registrar</b>  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 05826

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For State  
Registrar

Reg. No.

1. Decedent's Name (First, Middle, Last)

Vincent I. Thomas

2. Date of Death

Month Day Year  
February 19, 2011

3. Time of Death

0650 hrs

4a. Facility Name (if not institution, give street and number)

2800 Illinois Avenue

4b. City, Town, or Location of Death

Halethorpe

4c. County of Death

Baltimore County

5. Social Security Number

214-29-8637

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

20 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (MM/DD/YYYY)

05/12/1990

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

314 Lori Drive - Apt. J

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

3 ☐ Widowed 4 ☐ Divorced

If Yes, Give Year or Dates:

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stock Clerk

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Victor Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Valerie Thomas

19a. Informant's Name/Relationship (Type, Print)

Valerie Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

314 Lori Drive-Apt J, Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

2/25/2011

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Lloyd M. Estep

22. Name and Address of Facility

Estep Brothers Funeral Service, PA  
1300 Eutaw Place, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

Feb 18, 2011

28b. Time of Injury

2300 hrs

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) Field

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2800 Illinois Avenue, Halethorpe, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 20, 2011

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Diana J. Parks

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05827

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DANE NATHANIEL UPDIKE</b>  |  |   |  | 2. Date of Death<br>Month <b>FEB</b> Day <b>14</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>8:20 A M</b>  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>None</b>  |  | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs. _____  |  | 8. Date of Birth (Month, Day, Year)<br>Month <b>4</b> Day <b>27</b> Year <b>Feb. 14, 2011</b>      |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  |   |  |  |  |
|   | 10a. State<br><b>NY</b>   |  | 10b. County<br><b>Steuben</b>   |  | 10c. City, Town or Location<br><b>Hammondsport</b>  |  |  | 10d. Inside City Limits<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>57 Shether St., PO Box 85</b>  |  |   |  | 10f. Zip Code<br><b>14840</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><b>1</b> <input checked="" type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>0</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>   |  | 16b. Kind of Business Industry<br><b>N/A</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Nate Updike</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Christina Ingram</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nate &amp; Christina Updike-Parents</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PO Box 85 57 Shether St., Hammondsport, NY 14840</b>  |  |  |  |
|   | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>pleasant valley Cemetery</b>   |  | Date<br><b>2-19-2011</b>  |  | 20c. Location - City or Town, State<br><b>Hammondsport, NY</b>                                     |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>LaMarche Funeral Home 35 Main St., Hammondsport, NY 14840</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>EXTREME PREMATURITY</b>   |  |   |  |   |  |  |  |
| Approximate Interval Between Onset and Death  |   |  |   |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |   |  |  |  |
|   | a. Due to (or as a consequence of):   |  |   |  |   |  |  |  |
|   | b. Due to (or as a consequence of):   |  |   |  |   |  |  |  |
|   | c. Due to (or as a consequence of):   |  |   |  |   |  |  |  |
|   | d. Due to (or as a consequence of):   |  |   |  |   |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>9</b> <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
|   | 23c. If yes, outcome of pregnancy<br><b>1</b> <input type="checkbox"/> Live Birth <b>2</b> <input type="checkbox"/> Fetal death <b>3</b> <input type="checkbox"/> Ectopic pregnancy<br><b>4</b> <input type="checkbox"/> Pregnant at time of death <b>5</b> <input type="checkbox"/> Other (specify)  |  |   |  |   |  |  |  |
|   | 23d. Date of delivery<br>Month _____ Day _____ Year _____   |  |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |
|   | 23e. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No                                   |   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No |   |  |   |  |   |  |  |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) <b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <b>3</b> <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>A92703 (CA)</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/15/2011</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAY M. DINTAMAN MAJ MC USA NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>  |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |
|   | State Registrar   |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05828

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Suzanne Valentine

2. Date of Death

Month Feb 18, 2011 Year

3. Time of Death

7:03 A M

4a. Facility Name (If not institution, give street and number)

Future Care Of the Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

214-84-0073

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 14, 1963

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

97 Creekview Ct.

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Director of Childcare

16b. Kind of Business Industry

YWCA

17. Father's Name (First, Middle, Last)

Robert Calvert Baker

18. Mother's Name (First, Middle, Maiden Surname)

Carol Ann Zimmerman

19a. Informant's Name/Relationship (Type, Print)

Carol Ann Baker Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

704 Pinkney Ct., Newport News, VA 23601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

Feb 21, 2011

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature

K. Gregory Fink M01148

22. Name and Address of Facility

Fink Funeral Home, P.A.

426 Crain Hwy S., Glen Burnie, MD 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal cell cancer

Due to (or as a consequence of):

b. Metastases

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Hypertension

Approximate Interval Between Onset and Death

months

months

year

year

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

H. T. Davis MD

29c. License number

DS3111

29d. Date signed (Month, Day, Year)

02/18/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUNG T. DAVIS 2007 TIDEWATER COLONY I-A, ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

A. Davis

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05829

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry D. Watford

2. Date of Death

Month Day Year  
2 23 2011

3. Time of Death

8:18 PM

4a. Facility Name (if not institution, give street and number)

Mary Medical Center

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Funeral  
Director

5. Social Security Number

212 564 320

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/18/50

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3809 Terka Circle

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life, DO NOT use retired)

Ware-houseman

16b. Kind of Business Industry

Warehouse

17. Father's Name (First, Middle, Last)

Otis Watford

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Hoggett

19a. Informant's Name/Relationship (Type, Print) (Brother)

Mr. Bobby Watford

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3809 Terka Circle Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Cemetery

Date

3/5/2011

20c. Location - City or Town, State

Dundalk, MD

21. Signature of Funeral Service Licenses

Patella J. Harris, L.M.

22. Name and Address of Facility

Joseph L. Rios Funeral Home, P.A.  
2222 W. North Ave. Balto., MD 2121623a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. Gangrene

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Years

5 Weeks

5 Weeks

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

M

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan Andrews MD

29c. License number

D0067708

29d. Date signed (Month, Day, Year)

2/23/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Andrews 3018 Paul Place Baltimore, MD

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

John A. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05830

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Wilgis

2. Date of Death

February 14, 2011

3. Time of Death

9:28 P M

4a. Facility Name (if not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

220-24-7658

6. Sex

1 M 2 F

7. Age (in yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 28, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3939 Roland Ave #908

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates.

1948-

1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business Industry

Railroad

17. Father's Name (First, Middle, Last)

Elijah Edward Wilgis

18. Mother's Name (First, Middle, Maiden Surname)

Edna Murel Goodwin

19a. Informant's Name/Relationship (Type, Print)

Dora Wilgis - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2730 Hampden Ave; Baltimore, Maryland 21211

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board

655 W. Baltimore St; Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Heart Disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify)

9 Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0070182

29d. Date signed (Month, Day, Year)

2/15/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Trishena Jones

201 East University Parkway, Baltimore, MD  
Union Memorial Emergency Department

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Dora S. Wade

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

2011 05831

|   |  |   |  |   |
|---|--|---|--|---|
| Physician/<br>Medical Examiner  | 1- For State Registrar   |   | Reg. No.   |   |
|   | 1. Decedent's Name (First, Middle, Last)<br>JASON LEE WILLIAMS   |   | 2. Date of Death<br>Month Day Year<br>February 18, 2011  |   |
|   | 3. Time of Death<br>1630 hrs   |   |  |   |
|   | 4a. Facility Name (if not institution, give street and number)<br>Franklin Square Hospital   |   | 4b. City, Town, or Location of Death<br>Baltimore  |   |
| Funeral Director  | 4c. County of Death<br>Baltimore County  |   |  |   |
|   | 5. Social Security Number<br>212-96-3540   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                            | 7. Age (In yrs. last birthday)<br>30 Yrs.  | 8. Date of Birth (MM/DD/YYYY)<br>MARCH 6, 1980  |
|   | 9. Birthplace (State or Foreign Country)<br>MD   |   |  |   |
|   | Usual Residence of Decedent  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br>MD   | 10b. County<br>BALTIMORE  | 10c. City, Town or Location<br>ROSEDALE  |   |
|   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |
|   | 10e. Street and Number<br>6004 KENWOOD AVE   |   | 10f. Zip Code<br>21237   | 10g. Citizen of What Country?<br>USA  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9TH<br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MANAGEMENT  |   |
|   | 16b. Kind of Business/Industry<br>NIGHT CLUB   |   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br>BARRY K. WILLIAMS   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY DEBBIS   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>MARY WILLIAMS-MOTHER   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6004 KENWOOD AVE BALTIMORE, MD 21237  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GARDENS OF FAITH   | 20c. Location - City or Town, State<br>BALTIMORE, MD  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>MILLER-DIPPEL FUNERAL HOME, INC<br>6415 BELAIR RD BALTIMORE, MD 21206 |  |   |
| Physician<br>/Medical Examiner  | 23a. Part I. Enter the disease, injury, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Hypertensive Cardiovascular Disease Complicated by Alcohol and Chlordiazepoxide Use<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c.<br>Due to (or as a consequence of):<br>d.<br>Due to (or as a consequence of):<br><input checked="" type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED 23a, pt. II, 27 per me g913 3-9-11 vt |   |  | Approximate Interval Between Onset and Death  |
|   | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |
|   | 23d. Date of delivery<br>Month Day Year  |   |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cirrhosis of Liver   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred   |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |
|   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>O.C.M.E.  | 29d. Date signed (Month, Day, Year)<br>February 19, 2011  |
| 30. Name and address of person who completed cause of death (Item 23a)<br>Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |  |   |  |   |
| State Registrar   | 31. Date filed (Month, Day, Year)<br>FEB 25 2011   |   | 32. Registrar's Signature<br>  |   |

1- For State Registrar

Certificate of Death

Reg. No.

|  |   |                          |   |  |  |   |   |  |  |  |
|--|---|--------------------------|---|--|--|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WAYNE W. WIDERMAN</b>  |                          |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>February 21 2011</b>           |  | 3. Time of Death<br><b>1259PM</b>  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Northwest Hospital</b>   |                          |   |  |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b>             |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-50-2351</b>   |                          | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>12 64</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>March 20, 1946</b>            |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|  | Usual Residence of Decedent   |                          |   |  |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |                          | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>718 Leafydale Terrace</b>  |                          |   |  | 10f. Zip Code<br><b>21208</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates <b>Vietnam</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                          |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>US Army Corp of Engineers</b>  |   | 16b. Kind of Business Industry<br><b>Engineering</b>                    |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Raymond Widerman</b>  |                          |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ellen Lewis</b> |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Patricia Widerman (Spouse)</b>  |                          |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>718 Leafydale Terrace, Baltimore, MD 21208</b>   |   |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All County Cremation</b>   |  | Date<br><b>2/27/2011</b>   |   | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>      |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Don L. Hays M00764</b>  |                          |   |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL, PA<br/>PO Box 195 Sykesville, MD 21784</b>  |   |   |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Coronary Vascular Disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |                          |   |  |  |   |   |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year        |                          |   |  |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                          |   |  |  |   |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |                          |   |  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                          |   |  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                          |   |  |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |                          |   |  |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                          |   |  |  |   |   |  |  |  |
| 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br>M |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                               |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                          |   |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Christine Brand MD</b>   |   |                          |   | 29c. License number<br><b>D0057634</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 21, 2011</b> |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Northwest Hospital Emergency Department 5401 Old Court Rd Randallstown, MD 21133</b>  |   |                          |   |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |   |                          |   |  |  |   |   |  |  |  |
| 32. Registrar's Signature<br><b>Donna S. Parker</b>  |   |                          |   |  |  |   |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05833

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Virginia Lee Swartz Wilber

2. Date of Death

February 22, 2011

3. Time of Death

11:25 a M

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

217-34-0517

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/13/1936

9. Birthplace (State or Foreign Country)

IA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14051 Esworthy Road

10f. Zip Code

20874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Analyst

16b. Kind of Business Industry

Administration

17. Father's Name (First, Middle, Last)

John Lester Swartz

18. Mother's Name (First, Middle, Maiden Surname)

Martha May Ray

19a. Informant's Name/Relationship (Type, Print)

Jennifer Carr, niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20713 Woodthrush Ct. Sterling, VA 20165

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parklawn Mem. Gardens

Date

2/27/2011

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

M01539

22. Name and Address of Facility

Rapp Funeral &amp; Cremation Svcs.

933 Gist Ave. Silver Spring, MD 20910

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Cardiopulmonary Arrest

Approximate Interval Between Onset and Death

minutes

14 days

b. Due to (or as a consequence of):

Severe Pancreatitis

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

69148

29d. Date signed (Month, Day, Year)

02/22/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marichu T. Matas MD 10110 Molecular Drive Ste 2 Rockville, MD 20850

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

20



Reg. No.

32. Registrar's Signature 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

2011 05835

1- For State  
Registrar

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

James Woolford

2. Date of Death

February 18, 2011

3. Time of Death

0742 hrs

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

2009 Bear Ridge Road #3

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore County

5. Social Security Number

216-86-9086

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth (MM/DD/YYYY)

July 20-1962

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2009 Bear Ridge Road Apt #3

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Automotive Repairman

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

James L. Woolford

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Narman-Vanschaik

19a. Informant's Name/Relationship (Type, Print)

Tanya Woolford wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2009 Bear Ridge Road Apt #3, Dundalk, Md. 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory

Date

February 23, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A.

7110 Sollers Point Road, Dundalk, Md. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED 23a, pt. II, 27 per me g913 3-16-11 vt

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Clinical History of Chronic Obstructive Pulmonary

Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 19, 2011

30. Name and address of person who completed cause of death (Item 23a)

Mary G. Ripple MD, Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 23 2011

32. Registrar's Signature

James A. Spivey

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05836

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph Weiss

2. Date of Death

Month  
2Day  
19Year  
2011

3. Time of Death

2:30 P M

4a. Facility Name (if not institution, give street and number)

3013 ROMARIC COURT, #K

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-26-7390

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/03/1936

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3013 ROMARIC COURT, #K

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ATTORNEY

16b. Kind of Business Industry

LAW

17. Father's Name (First, Middle, Last)

LOUIS

18. Mother's Name (First, Middle, Maiden Surname)

WEISS

19. Informant's Name/Relationship (Type, Print)

MARNI THIESS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

408 DONEGAL DRIVE, BALTIMORE, MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERANS

Date

03/04/2011

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Scott M. Gottle

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

Approximate Interval Between Onset and Death

11 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sandra Marshall

29c. License number

D0035363

29d. Date signed (Month, Day, Year)

2/20/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sandra Marshall BVAMC 10 N. Greene St. Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Sandra D. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05837

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alma Inez Youngbar

2. Date of Death

Month February Day 22, Year 2011

3. Time of Death

3:00 P. M

4a. Facility Name (if not institution, give street and number)

3701 Pascal Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

260 14 6603

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 12/06/1920

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3701 Pascal Avenue

10f. Zip Code

21226

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Food Supervisor

16b. Kind of Business Industry

Food Services

17. Father's Name (First, Middle, Last)

Mattie Will Jordan

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Elizabeth Walden

19a. Informant's Name/Relationship (Type, Print)

Theresa Ennis / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3701 Pascal Avenue Baltimore, Maryland 21226

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Mem. Park

Date

02/28/2011

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

*Donna M. Zromkowski*

22. Name and Address of Facility

Gonce Funeral Service, P.A.  
4001 Ritchie Highway Baltimore, Maryland 21225

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

*Adenocarcinoma of Lung*

Approximate Interval Between Onset and Death

*3 months*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Metastatic Disease to Liver*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Colvin C. Carter MD*

29c. License number

*D0001459*

29d. Date signed (Month, Day, Year)

*Feb. 23, 2011*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Colvin C. Carter, MD 5505 E Ritchie Hwy Balto. MD 21225*

31. Date filed (Month, Day, Year)

*FEB 23 2011*

32. Registrar's Signature

*Donna M. Zromkowski*State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05838

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Zimbler

2. Date of Death

Month Day Year  
February 22, 2011

3. Time of Death

6:45 pm<sup>M</sup>

4a. Facility Name (if not institution, give street and number)

Brook Grove Nursing Center

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

322-14-8655

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

8. Date of Birth

If Under 1 Year  
Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 23, 1921

9. Birthplace (State or Foreign Country)

Chicago, IL

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Sandy Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

18131 Slade School Road

10f. Zip Code

20860

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business Industry

Retail Dept. Store

17. Father's Name (First, Middle, Last)

Morris Gottstein

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Ehrlich

19a. Informant's Name/Relationship (Type, Print)

Shelly Zimbler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33301  
350 SE Second Street Apt. 2170 Ft. Lauderdale, FL

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth Shalom Cemetery

Date

2/27/11

20c. Location - City or Town, State

Oregon, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert H. Wick/Wisniewski FH  
2426 North Reynolds Rd. Toledo, OH 43615

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

DYSPHAGIA

1 MONTH

c. Due to (or as a consequence of):

ENDSTAGE SENILE DEMENTIA

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33700

29d. Date signed (Month, Day, Year)

February 24, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TED HOWE 154 N. ARTIZAN ST, WILLIAMSPORT, MD 21795

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05839

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ying Zhang</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>February 21, 2011</b>   |  | 3. Time of Death<br><b>10:20A<sup>M</sup></b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Casey House</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| 5. Social Security Number<br><b>220-55-5955</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>July 2, 1970</b>   | 9. Birthplace (State or Foreign Country)<br><b>China</b> |  |  |
| Usual Residence of Decedent   |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Rockville</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1001 Rockville Pike Apt 617</b>  |  |  |  | 10f. Zip Code<br><b>20852</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Paralegal</b>  |  | 16b. Kind of Business Industry<br><b>Law Firm</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Xuexiao Zhang</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Yu Yuan</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George Chu/husband</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 Rockville Pike Apt 617 Rockville, MD 20852</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Final Journey Crematory</b>   |  | Date<br><b>2/25/2011</b>   |  | 20c. Location - City or Town, State<br><b>Woodbine, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Quanta R Thomas</b> M00957  |  |  |  | 22. Name and Address of Facility<br><b>Going Home Cremation Service P.O. Box 784<br/>Beverly L. Heckrotte, P.A. Clarksville, MD 21029</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cecal Carcinoma</b><br>Due to (or as a consequence of):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input checked="" type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |  |  | 29c. License number<br><b>D37142</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-21-2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>G. Coleman, M.D. 1355 Piccard Drive Rockville, Maryland 20850</b>  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05840

## Certificate of Death

Reg. No.

1 For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Willard Abell, Sr.

2. Date of Death

February 10, 2011

3. Time of Death

9:05 PM

4a. Facility Name (if not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

213-80-6267

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

June 25, 1960

9. Birthplace (State or Foreign Country)

Maryland

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39924 Graves Road

10f. Zip Code

20659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business Industry

Construction

17. Father's Name (First, Middle, Last)

Joseph Bernard Abell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ann Hope Clarke

19a. Informant's Name/Relationship (Type, Print)

Mildred Denise Abell / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39924 Graves Road, Mechanicsville, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Charles Memorial Gardens

Date

February 16,  
2011

20c. Location - City or Town, State

Leonardtown, Maryland

21. Signature of Funeral Service Licensee

Michael S. Gardiner

22. Name and Address of Facility  
Mattingley-Gardiner Funeral Home, P.A.  
P.O. box 270, Leonardtown, MD 2065023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Lawrence M.D.

29c. License number

D 60888

29d. Date signed (Month, Day, Year)

02/11/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan, MD., 26840 Point Lookout Road, Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

D. Lawrence

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permitted. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Joan D. Adams</u>  |   | 2. Date of Death<br>Month <u>February</u> Day <u>10</u> , Year <u>2011</u>  |  | 3. Time of Death<br><u>0015</u> M  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Union Hospital</u>   |   | 4b. City, Town, or Location of Death<br><u>Elkton</u>   |  | 4c. County of Death<br><u>Cecil</u>  |
| Funeral<br>Director  | 5. Social Security Number<br><u>215-28-8202</u>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>77</u> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><u>07/25/1933</u>   | 9. Birthplace (State or Foreign Country)<br><u>Pennsylvania</u>  |
|  | Usual Residence of Decedent   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><u>MD</u>   | 10b. County<br><u>Cecil</u>   | 10c. City, Town or Location<br><u>Rising Sun</u>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><u>6 Curtis Drive</u>   |   | 10f. Zip Code<br><u>21911</u>   | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.,<br>Specify: <u>White</u>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Medical</u>  |
|  | 16b. Kind of Business Industry<br><u>Assistant</u>  |   | 17. Father's Name (First, Middle, Last)<br><u>Earl R. Day</u>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Pearl Doris Fletcher</u>   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Sharon McGrath (Daughter)</u>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>31281 Edgewood Drive, Lewes, DE 19958</u>   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>R.A. Ferris &amp; Co. Inc.</u>   |  | 20c. Location - City or Town, State<br><u>West Chester, PA</u>   |
|  | 21. Signature of Funeral Service Licensee<br><u>Yara C. Zellman</u>   |   | 22. Name and Address of Facility<br><u>Zellman Funeral Home, P.A.</u><br><u>123 S. Washington Street, Havre de Grace, MD</u>  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><u>Atrial Fibrillation</u><br>Due to (or as a consequence of):<br><u>CHF</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD</u><br><u>Seizures</u>   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u> MD   |   | 29c. License number<br><u>D0062190</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>2/10/2011</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>SHAHNAWAZ KHAN MD III W. HIGH ST., SUITE 314, ELKTON, MD 21921</u>  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>FEB 14 2011</u>  |   | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05842

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lester Gordon Aisquith

2. Date of Death

Month 2 Day 7 Year 2011

3. Time of Death

17:23 M

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

215-38-9489

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Aug. 6, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Riva

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

P.O. Box 239

10f. Zip Code

21140

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates. 1955-5713. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: white15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
School Bus Contractor

16b. Kind of Business Industry

Anne Arundel County

17. Father's Name (First, Middle, Last)

Raymond Aisquith

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Davis

19a. Informant's Name/Relationship (Type, Print)

Gary Aisquith/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1290 Anglesey Drive Riva, Maryland 21140

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hillcrest Mem. Gardens

Date

2/12/2011

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

Todd E. Tillu

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St., Annapolis, MD 21401

Physician/  
Medical  
Examiner23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Cardiac arrest

Due to (or as a consequence of):

b. Hypotension

Due to (or as a consequence of):

c. Dehydration

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Immediate

30 minutes

1 day

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia  
Restrictive lung disease  
Ankylosing spondylitis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Friend M.D.

29c. License number

017965

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Friend 116 Defense Hwy Annapolis, Md. 21401

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Annun B. Spaw

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Atkinson

2. Date of Death

Month

Day

Year

2 7 2011

3. Time of Death

12:34 PM

4a. Facility Name (if not institution, give street and number)

University of Maryland Shock Trauma

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

225-60-7483

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)  
Aug. 8, 1946

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1392 Chillum Road

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business Industry

Private

17. Father's Name (First, Middle, Last)

Unk

18. Mother's Name (First, Middle, Maiden Surname)

Hattie McGee

19a. Informant's Name/Relationship (Type, Print)

Mary E. Atkinson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1392 Chillum Road  
Hyattsville, MD 20782

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Heritage Memorial Cemetery

Date

2/12/11

20c. Location - City or Town, State

Waldorf, Md.

21. Signature of Funeral Service Licensee

Price Edwards

22. Name and Address of Facility

Hodges &amp; Edwards F.H.

3910 Silver Hill Rd., Suitland, Md. 20746

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Intracerebral Hemorrhage

Due to (or as a consequence of):

b.

Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Chiu MD

29c. License number

P25089

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Chiu MD 22 S Greene St Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Anna B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET ELLEN AUSTEN</b>   |  | 2. Date of Death<br>Month <b>02</b> Day <b>11</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>3:10 PM</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL CENTRAL</b>  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |   | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |   |
| 5. Social Security Number<br><b>473-50-1956</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 13, 1944</b>   | 9. Birthplace (State or Foreign Country)<br><b>Green Bay, Wisconsin</b>  |   |
| Usual Residence of Decedent  |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>College Park</b>  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>4613 Calvert Road, #2</b>   |  | 10f. Zip Code<br><b>20740</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |   |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesperson</b>  |  | 16b. Kind of Business Industry<br><b>Automotive</b>   |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>John K. O'Connell</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Wilma M. Mason</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kim A. O'Connell / Niece</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 16th Street South, Arlington, VA 22202</b> |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Ernest James Colvin II</b>   |  | 22. Name and Address of Facility<br><b>4739 Baltimore Avenue<br/>Gasch's Funeral Home, P.A. Hyattsville, MD 20781</b>   |   |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):<br><b>LUNG CANCER WITH METASTASES</b><br>Approximate Interval Between Onset and Death<br><b>1 YEAR</b>   |  |   |   |  |   |
| 23b. IF FEMALE: Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown  |  |   |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |   |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier<br>(Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |
| 29b. Signature and title of certifier<br><b>GARRETT MARTIN M.D.</b>  |  | 29c. License number<br><b>D67934</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>02/11/2011</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GARRETT MARTIN 3001 HOSPITAL DRIVE CHEVERLY, MD</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05845

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Victor Roy Anderson

2. Date of Death

Feb 2 Day 2011 Year

3. Time of Death

12:00 p M

4a. Facility Name (if not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

086-54-3207

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 30, 1925

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12006 Manchester Way

10f. Zip Code

20720

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Furniture Entrepreneur

16b. Kind of Business Industry

Anderson Furniture

17. Father's Name (First, Middle, Last)

John Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Viola Lyttle

19a. Informant's Name/Relationship (Type, Print)

Lloyd Anderson - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13108 Jordans Endeavor Dr. Bowie, MD. 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland National Cem 2-11-2011

Date

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

Victorine C. Woods

22. Name and Address of Facility

Marshall-March Funeral Home of MD  
4308 Suitland Rd. Suitland, MD 2074623a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Hemorrhage

Due to (or as a consequence of):

b. Prostate Cancer

Due to (or as a consequence of):

c. Seizure Disorder

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Norman Smith

29c. License number

D41240

29d. Date signed (Month, Day, Year)

2/5/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norman Smith, MD 2905 Mitchellville Rd. #104 Bowie, MD 20716

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Norman Smith

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

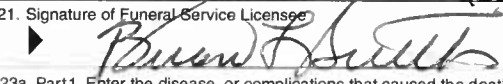
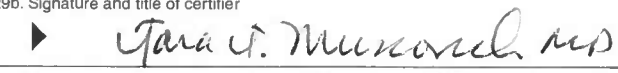

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar



Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lillian R. Ames</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>4</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>6:30 p.m.</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Crofton Covalescent Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Crofton</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| 5. Social Security Number<br><b>214-07-2581</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>March 29, 1911</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Keyser, WV</b> |
| Usual Residence of Decedent  |  |   |  |  |   |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Gambrills</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>1260 Defense Highway</b>  |  | 10f. Zip Code<br><b>21054</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>College (1-4or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Resident Manager</b>   |   |
| 16b. Kind of Business/Industry<br><b>Senior Citizen Low Income Housing</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Albert E. Rice</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lurenia McIlwee</b>  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William H. Davis/Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2318 Seabury Drive Crofton, MD 21114</b>  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Queen's Point Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Keyser, WV</b>   |   |
| 20d. Date<br><b>Feb. 9</b>   |  |   |  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Smith Funeral Home<br/>85 S. Main Street Keyser, WV 26726</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>20 years</b> |  |   |  |  |   |
| 23b. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |   |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown   |  |   |  |  |   |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia, Emphysema, Gastroesophageal reflux, Chronic renal insufficiency, Cerebrovascular disease,</b>   |  |   |  |  |   |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>046992</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02/15/11</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Tara Muscovich, M.D. 1438 Defense Highway, Suite 201 Gambrills, MD 21057</b>  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br>  |  |  |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05847

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |
|--|--|---|---|---|--|--|
| Physician/<br>Medical<br>Examiner                                  | 1. Decedent's Name (First, Middle, Last)<br>Thomas Lee Barnett   |   | 2. Date of Death<br>Month Day Year<br>February 6, 2011  |   | 3. Time of Death<br>1347 P M   |  |
|  | 4a. Facility Name (if not institution, give street and number)<br>229 Baltimore Ave, Apt. 904  |   | 4b. City, Town, or Location of Death<br>Cumberland  |   | 4c. County of Death<br>Allegany  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-02-4929   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>47 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>06/15/1963       | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |   |   |   |  |  |
| To Be Completed by Funeral Director                                | 10a. State<br>MD   | 10b. County<br>Allegany   | 10c. City, Town or Location<br>Cumberland   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>229 Baltimore Ave, Apt. 904  |   | 10f. Zip Code<br>21502  | 10g. Citizen of What Country?<br>USA                    |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maintenance  |   | 16b. Kind of Business Industry<br>Office Building  |  |
| To Be Completed by Physician/Medical Examiner                      | 17. Father's Name (First, Middle, Last)<br>Paul William Barnett  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sylvia May Simmons   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>William P. Barnett / Brother   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>555 B Street, LaVale, MD 21502   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Frostburg Memorial Park   |   | 20c. Location - City or Town, State<br>02/09/2011 Frostburg, MD  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br>Williams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502  |   |  |  |
| Physician/<br>Medical<br>Examiner                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Atherosclerotic Cardiovascular disease</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   | Approximate Interval Between Onset and Death<br>6 months   |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| Medical Certificate: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M                                | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.         |   |   |   |  |  |
|  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>D0055325   | 29d. Date signed (Month, Day, Year)<br>February 7, 2011 |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Wonsock Shin, M.D., 925 Bishop Walsh Road, Cumberland, MD 21502  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 07 2011                   |  | 32. Registrar's Signature<br>   |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.


Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Req. No.**

|   |  |
|---|--|
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b> | 32. Registrar's Signature<br> |
|---|--|

FEB 09 2011

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05849

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Jane Brawley

2. Date of Death

Month  
FebruaryDay  
12Year  
2011

3. Time of Death

4:20 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

577-32-7678

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

Month, Day, Year  
June 13, 1927

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27130 Widow Lane

10f. Zip Code

20659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business Industry

Retail

17. Father's Name (First, Middle, Last)

Elmer William Howerton

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Adelia O'Connor

19a. Informant's Name/Relationship (Type, Print)

Dorothy Vallandingham/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27130 Widow Lane Mechanicsville, Maryland 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Memorial Gardens

Date

February 17,

2011

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

Michael R. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270 Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Lung carcinoma

b. Due to (or as a consequence of):

Pulmonary embolus

c. Due to (or as a consequence of):

CO PD

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dane

29c. License number

D60888

29d. Date signed (Month, Day, Year)

02/12/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan, MD., 26840 Point Lookout Road, Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Dane B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Brawley, Margaret, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05850

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter LeRoy Burall

2. Date of Death

Month Day Year  
February 7 2011

3. Time of Death

11:59a M

4a. Facility Name (if not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

214-32-3941

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

8. Date of Birth (Month, Day, Year)

June 2, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

New Market

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11833 Lime Plant Road

10f. Zip Code

21774

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Meat Inspector

16b. Kind of Business Industry

USDA

17. Father's Name (First, Middle, Last)

Jessie M. Burall

18. Mother's Name (First, Middle, Maiden Surname)

Flora Mae Delauter

19a. Informant's Name/Relationship (Type, Print)

Mae Burall / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11833 Lime Plant Road, New Market, Maryland 21774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Hill Cemetery

Date

2/12/2011

20c. Location - City or Town, State

Monrovia, Maryland.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home P. A.  
1621 Opossumtown Pike, Frederick, Maryland 21701

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks.

5 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death 5 ☐ Ectopic pregnancy  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia 2 wks.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-13971

29d. Date signed (Month, Day, Year)

2/9/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert L. Kaufmann MD 300 West 9th Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Matthew Blair

2. Date of Death

February 12, 2011

3. Time of Death

10:20 a.m.

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

St. Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

5. Social Security Number

220-34-8805

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

8. Date of Birth

(Month, Day, Year)

12/21/1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

St. Inigoes

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

48030 Cross Manor Road

10f. Zip Code

20684

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Walter Rayner Blair

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gladys Bailey

19a. Informant's Name/Relationship (Type, Print)

Marian Ann Blair/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

48030 Cross Manor Road, St. Inigoes, MD 20684

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Michael's Cemetery

Date

02/16/2011

20c. Location - City or Town, State

Ridge, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, MD 2065023a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

Terminal Cachexia

b. Due to (or as a consequence of):

Lewy Body Dementia

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 wks

4 years

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

James P. Jarboe, M.D.

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

2-15-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James P. Jarboe, M.D. 24035 Three Notch Road, Hollywood, MD 20636

31. Date filed (Month, Day, Year)

FEB 16 2011

32. Registrar's Signature

Denise A. Jones

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05852

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAURENCE BURGESS

2. Date of Death

Month 02 Day 08 Year 2011

3. Time of Death

11:40 PM

4a. Facility Name (if not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

221-34-3915

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 20, 1950

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30993 Tail Feather Run

10f. Zip Code

19956

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. 1968-1971

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

lead inspector

16b. Kind of Business Industry

sanitation

17. Father's Name (First, Middle, Last)

Romie Burgess

18. Mother's Name (First, Middle, Maiden Surname)

Juanita Edgington

19a. Informant's Name/Relationship (Type, Print)

Andrea S. Burgess (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30993 Tail Feather Run Laurel, DE 19956

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva

Date

Feb. 10, 2011

20c. Location - City or Town, State

Delmar, Delaware

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Short Funeral Home

13 East Grove Street Delmar, DE 19940

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. Bacteremia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

24 hrs

48 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory failure / lung transportation  
Renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

P24392

29d. Date signed (Month, Day, Year)

02/09/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSE AMOROSO 22 S. GREENE ST. BALTIMORE, MD. 21201

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 26 per med cert G913 3/8/11 dk  
State of Maryland / Department of Health and Mental Hygiene

Reg. No.

2011 05853

## Certificate of Death

1- For State Registrar

|   |   |   |   |  |  |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Essie Mae Baker Blue</b>   |   |   |  |  |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>06</b> Year <b>2011</b>        |  | 3. Time of Death<br><b>12:15 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>129 Branch Street</b>  |   |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>                      |  | 4c. County of Death<br><b>Worcester</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>246-16-4165</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 17, 1921</b>                 |  | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Berlin</b>   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>10403 Griffin Road</b>   |   |   |  | 10f. Zip Code<br><b>21811</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African-American</b>   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>9</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeper</b>   |  | 16b. Kind of Business/Industry<br><b>Various</b>   |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Kale Stephens</b>   |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Easter Grasham</b> |  |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Duffy/daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>129 Branch St., Berlin, MD 21811</b>   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Paul's Cemetery</b>  |  | Date<br><b>02/12/2011</b>  |  | 20c. Location - City or Town, State<br><b>Berlin, MD</b>                   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Talana D. Watson</i>  |   |   |  | 22. Name and Address of Facility<br><b>Lewis N. Watson Funeral Home, PA<br/>1618 West Rd., Salisbury, MD 21801</b>   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. <b>Pancreatic Cancer liver mets</b><br>Due to (or as a consequence of):<br>b. <b>Diabetes mellitus</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d. <b>Hyperlipidemia</b> |   |   |  |  |  |  |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____                  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>daughter's residence</b> |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M _____         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Jeffrey R. Schinner PC</i>  |   | 29c. License number<br><b>H0066462</b> |  | 29d. Date signed (Month, Day, Year)<br><b>2-9-11</b>                                 |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeffrey R. Schinner PC 10514 Baretteck Rd Unit C Berlin MD 21811</b>   |   |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |   | 32. Registrar's Signature<br><i>Anna B. Parker</i>  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05854

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Rosa L. Burrell

2. Date of Death

January 26 2011

3. Time of Death

1315 M

4a. Facility Name (if not institution, give street and number)

Prince Georges Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

246-60-5834

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 7, 1938

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13946 King George Way

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurses Aid

16b. Kind of Business Industry

Public Health

17. Father's Name (First, Middle, Last)

William Venable

18. Mother's Name (First, Middle, Maiden Surname)

Victoria Holloway

19a. Informant's Name/Relationship (Type, Print)

Audrey Jones/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13946 King George Way  
Upper Marlboro, Md. 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Church Cemetery

Date

2/1/11

20c. Location - City or Town, State

Henderson, NC

21. Signature of Funeral Service Licensee

Janice Edwards

22. Name and Address of Facility

Hodges &amp; Edwards F.H.

3910 Silver Hill Rd., Suitland, Md. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. FATAL CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide 6 ☐ determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samreen Khan MD

29c. License number

D71091

29d. Date signed (Month, Day, Year)

2/2/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMREEN KHAN MD

3001 HOSPITAL DRIVE

CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

S. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05855

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Baer, Sr.

2. Date of Death

Month February Day 17 Year 2011

3. Time of Death

12:00

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Egle Nursing and Rehab Center

4b. City, Town, or Location of Death

Lonaconing

4c. County of Death

Allegany

5. Social Security Number

220-16-5608

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 28, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Lonaconing

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

57 Jackson Street

10f. Zip Code

21539

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Second (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business Industry

Construction

17. Father's Name (First, Middle, Last)

Albert Baer

18. Mother's Name (First, Middle, Maiden Surname)

Mary Leptic

19a. Informant's Name/Relationship (Type, Print)

Richard Baer, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 South Waverly Terrace, Cumberland, Maryland, 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cumberland Crematory

Date

February 18,  
2011

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

Brandi Wilhelm

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home P.A.  
8 East Main Street Lonaconing, MD 2153923a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Coronary Artery Disease  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease  
History of Cerebrovascular accident

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Baer

29c. License number

D21244

29d. Date signed (Month, Day, Year)

2/17/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeru Tan MD, 4 Broadway, Frostburg, Maryland, 21532

31. Date filed (Month, Day, Year)

FEB 23 2011

32. Registrar's Signature

J. Baer

State  
RegistrarBaltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05856

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cecil Beeman, Jr.

2. Date of Death

2/13/11

Month Day Year

3. Time of Death

0054

A

4a. Facility Name (If not institution, give street and number)

Western Maryland Health System Cumberland

4b. City, Town, or Location of Death

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

213-24-5597

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 16, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Midland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15412 Warnick Road

10f. Zip Code

21542

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Second (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grave Digger

16b. Kind of Business Industry

Cemetery

17. Father's Name (First, Middle, Last)

Cecil Ellis Beeman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Eva Fazenbaker

19a. Informant's Name/Relationship (Type, Print)

Carolyn Brabson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Route 1 Virginia Street, Ridgeley, West Virginia, 26753

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. View Cemetery

Date

February 17, 2011

20c. Location - City or Town, State

Moscow Mills, Maryland

21. Signature of Funeral Service Licensee

Brandi Wilhelm

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home P.A.

8 East Main Street Lonaconing, MD 21539

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asthma exacerbation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes, Coronary artery disease, atrial tachycardia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow M.D.

29c. License number

Do9157

29d. Date signed (Month, Day, Year)

Feb 14 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow M.D. Dpty Med ex 124 W 3rd St Cumberland MD 21502

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Lenna P. Spake

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05857

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Elmer Blevins

2. Date of Death

February 15 2011

3. Time of Death

1:15P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

Baltimore

5. Social Security Number

413-38-9885

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 13, 1930

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4811 Dave Rill Road

10f. Zip Code

21072

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. 1951-1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cabinet Maker

16b. Kind of Business Industry

Lumber

17. Father's Name (First, Middle, Last)

Paul M. Blevins

18. Mother's Name (First, Middle, Maiden Surname)

Annis V. Robbins

19a. Informant's Name/Relationship (Type, Print)

Roselee G. Blevins/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4811 Dave Rill Rd., Hampstead, MD 21072

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Abrahams

Date

Feb. 21 2011

20c. Location - City or Town, State

Beckleysville, MD

21. Signature of Funeral Service Licensee

Michael W. Hartenstein

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 N. Second St. New Freedom, PA 17349

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Distress Syndrome

Due to (or as a consequence of):

b. Kidney Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Imran E. Siddiqi MD

29c. License number

D0063974

29d. Date signed (Month, Day, Year)

2/15/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Imran E. Siddiqi M.D 7601 Osler Drive Towson MD 21204

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Laura B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05858

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Charles Cook

2. Date of Death

Month 1 Day 22 Year 11

3. Time of Death

1440 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

WMHS-Regional Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

5. Social Security Number

214-07-5263

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

1-14-1914

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

BEDFORD

10c. City, Town or Location

HYNDMAN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3547 HYNDMAN RD

10f. Zip Code

15545

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business Industry

Textile manufacture

17. Father's Name (First, Middle, Last)

J. HOWARD Cook

18. Mother's Name (First, Middle, Maiden Surname)

Annie Belle Rizer

19a. Informant's Name/Relationship (Type, Print)

JANET HOLLER / DGH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

140 Bedford St. PO Box 446, HYNDMAN PA 15545

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HYNDMAN CEM.

Date

1-26-2011

20c. Location - City or Town, State

HYNDMAN PA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HARVEY H. ZEIGLER FH INC  
169 Clarence St HYNDMAN PA 15545

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute on chronic renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D 56207

29d. Date signed (Month, Day, Year)

January 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSAM SEMAAN 12502 Willowbrook RD Cumberland MD 21502

31. Date filed (Month, Day, Year)

JAN 24 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

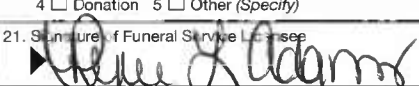
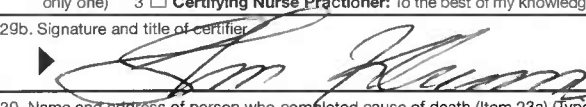
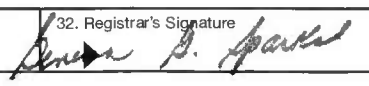
State of Maryland / Department of Health and Mental Hygiene

2011 05859

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edith E. Cesnick</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>1217 P M</b>  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Western MD Regional Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-22-5149</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>10/14/1913</b>       |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |  | Usual Residence of Decedent   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Allegany</b>   | 10c. City, Town or Location<br><b>Cumberland</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>432 N. Centre Street</b>   |  | 10f. Zip Code<br><b>21502</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                          |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Proprietor</b>  |  | 16b. Kind of Business Industry<br><b>Retail</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Albert Bland</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Kallmyer</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Christopher D. Arnold/ Nephew</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>424 Bentley Oak Lane, Centerville, OH 45458</b>   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>02/08/2011 Cumberland, MD</b>  |
|  | 21. Signature of Funeral Director<br>  |  | 22. Name and Address of Facility<br><b>Adams Family Funeral Home, P.A.<br/>404 Decatur Street, Cumberland, MD 21502</b>                               |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia, Atrial Fibrillation</b>   |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br>M                                       |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D0054004</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>February 5, 2011</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shiv C. Khanna, M.D., 1221-E National Highway, LaVale, MD 21502</b>   |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>FEB 07 2011</b>   |  | 32. Registrar's Signature<br>                                      |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert W. Cash</b>   |   |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> , Year <b>2011</b>  |  | 3. Time of Death<br><b>12:15 p M</b>   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>112 Pleasant Grove Road</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Conowingo</b>   |  | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>211-20-5473</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 25, 1930</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Conowingo</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>112 Pleasant Grove Road</b>  |  | 10f. Zip Code<br><b>21918</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) Twelve Years</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                         |  | 16b. Kind of Business Industry<br><b>Construction</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Green Lee Cash</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Verta Howell</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Russell J. Cash (son)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>112 Pleasant Grove Rd., Conowingo, MD 21918</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bethesda United Methodist Cemetery</b>                                   |  | Date<br><b>02/12/11</b>  |  | 20c. Location - City or Town, State<br><b>Martic Township, Pennsylvania</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Thomas M. Patterson Sr.</i>   |   |   |  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home, P.A.<br/>Perryville, Maryland 21903-0766</b>   |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br>b. <b>Squamous Cell Lung Cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>years</b><br><b>months</b> |   |   |  |  |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |   |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Chronic Kidney Disease</b>  |   |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Son's Home</b> |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   |   |   | 29c. License number<br><b>D0065827</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/9/2011</b>                               |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Angela Pope Rios 500 Upper Chesapeake Dr Bel Air MD 21014</b>  |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |   |   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05861

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |   |  |
|--|--|---|---|---|--|--|---|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Francis Combs</b>   |   |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>3:30 A M</b>                                     |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>26258 Three Notch Road</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Mechanicsville</b>  |  | 4c. County of Death<br><b>St. Mary's</b>                                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-26-6666</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 22, 1923</b>           |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |   |  |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   |   |   |  |  |   |  |
|  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>St. Mary's</b>  |   | 10c. City, Town or Location<br><b>Mechanicsville</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br><b>26258 Three Notch Road</b>  |   |   |   | 10f. Zip Code<br><b>20659</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Insurance Salesman</b>   |  | 16b. Kind of Business Industry<br><b>Insurance</b>                      |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Paul Barnes</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lily Mae Barnes</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia Ann Jones/ Daughter</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>913 Licklog Road Newland, North Carolina 28657</b>                                       |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Cemetery</b>  |   | Date <b>February 18, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Hollywood, Maryland</b>       |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael R. Gardiner</i>  |   |   |   | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270 Leonardtown, Maryland 20650</b>   |  |   |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>gangrene</b><br><b>peripheral arterial disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |   |   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's dementia</b>  |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M                        |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred               |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Jennifer Schmidt</i>   |  |   |   | 29c. License number<br><b>M0055751</b>          |  | 29d. Date signed (Month, Day, Year)<br><b>2-18-11</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jennifer Schmidt DO 40900 Merchants Lane Ste. 205 Leonardtown, Maryland 20650</b>   |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 16 2011</b>  |  |   |   | 32. Registrar Signature<br><i>Anna S. Parks</i> |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05862

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |   |  |                                 |  |  |  |                                   |  |  |  |  |
|---|--|---|--|---------------------------------|--|--|--|-----------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Billie Ann Cook  |   |  |                                 | 2. Date of Death<br>Month February Day 2, Year 2011  |  |  |                                   | 3. Time of Death<br>9:00 A M   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3140 Perrywinkle Court   |   |  |                                 | 4b. City, Town, or Location of Death<br>Adamstown  |  |  |                                   | 4c. County of Death<br>Frederick   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>374-24-1190   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |                                 | 7. Age (In yrs. last birthday)<br>83 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 3, 1927               |                                   | 9. Birthplace (State or Foreign Country)<br>Illinois   |  |  |  |
|   | Usual Residence of Decedent  |   |  |                                 |  |  |  |                                   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |   | 10b. County<br>Frederick   |                                 | 10c. City, Town or Location<br>Adamstown   |  |  |                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br>3140 Perrywinkle Court   |   |  |                                 | 10f. Zip Code<br>21710   |  | 10g. Citizen of What Country?<br>United States                   |                                   |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2   |   |  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  | 16b. Kind of Business/Industry<br>Own Home                       |                                   |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Forrest Lee Frazier   |   |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kathryn Cornelia Pratt  |  |  |                                   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Allyn Buzzell / Daughter   |   |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2906 Bidle Road, Middletown, MD 21769   |  |  |                                   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenmount Crematory   |                                 | Date<br>Feb. 5, 2011   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland       |                                   |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee  |   |  |                                 | 22. Name and Address of Facility<br>Resthaven Funeral Services, Skkot Cody P.A.<br>9501 Catocin Mountain Hwy. Frederick, MD 21701  |  |  |                                   |  |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Atherosclerotic Vascular Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |                                 |  |  |  |                                   |  |  | Approximate Interval Between Onset and Death |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |                                 | 3 <input type="checkbox"/> Ectopic pregnancy   |  | 23d. Date of delivery<br>Month Day Year                          |                                   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |                                 |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                 |  |  |  |                                   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |  |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |                                 |  |  |  |                                   |  |  |  |  |
| 29b. Signature and title of certifier   |  |   |  | 29c. License number<br>D0058726 |  | 29d. Date signed (Month, Day, Year)<br>February 3, 2011  |  |                                   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Yvette Warren, M.D. 6000 Ventrie Circle, Myersville, MD 21773   |  |   |  |                                 |  |  |  |                                   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 08 2011  |  | 32. Registrar's Signature   |  |                                 |  |  |  |                                   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

2011 05863

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |   |   |  |   |  |
|---|---|---|---|---|---|--|---|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Arelela Edna Mae Hull Cray</b>   |   |   |   | 2. Date of Death<br>Month <b>02</b> Day <b>04</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>10:05 PM</b>                                     |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Coastal Hospice at the Lake</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Salisbury</b>  |  | 4c. County of Death<br><b>Wicomico</b>                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-36-5119</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1939</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Wicomico</b>  |  | 10c. City, Town or Location<br><b>Mardela Springs</b>                   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>25321 Ocean Gateway</b>  |   | 10f. Zip Code<br><b>21837</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired Teacher</b>   |   | 16b. Kind of Business Industry<br><b>Talbot and Wicomico County Board of Education</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Albert Hull</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Gertrude Dashiell</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gene Cray/ Husband</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21837 25321 Ocean Gateway - Mardela Springs, Maryland</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Springhill Memory Gardens</b>  |   | Date<br><b>Feb. 12, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Hebron, Maryland</b>          |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Patricia A. Jolley</i>  |   |   |   | 22. Name and Address of Facility<br><b>1213 Jersey Road 21801 Jolley Memorial Chapel - Salisbury, Maryland</b>  |  |   |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Endometrial Carcinoma with lung mets</b> |   |   |   | Approximate Interval Between Onset and Death<br><b>months</b>   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.                                       |   |   |   |   |  |   |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) |   | 23d. Date of delivery<br>Month Day Year   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>   |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Gregorio M. Bellosso M.D.</i>   |   | 29c. License number<br><b>D 29505</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>02-05-2011</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GREGORIO M. BELLOSO, 5302 CHINABERRY DR, SALISBURY, MD 21801</b>   |   |   |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |   | 32. Registrar's Signature<br><i>Anna D. [Signature]</i>   |   |   |   |  |   |  |

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

2011 05864

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>FRED A D. CONLEY</b>  |  | 2. Date of Death<br>Month <b>06</b> Day <b>06</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>1500</b> M  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Rutherford Manor</b>  |  | 4b. City, Town, or Location of Death<br><b>Davidsonville</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>236 20 7340</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  |
| 8. Date of Birth<br>Month <b>02</b> Day <b>20</b> Year <b>1922</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  |  |  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Edgewater</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3752 Colliers Drive</b>   |  | 10f. Zip Code<br><b>21037</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College <b>5+</b> or 5+   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Educator</b>   |  | 16b. Kind of Business Industry<br><b>Secondary Schools</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Albert Dodge</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Verna Groves</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce Conley (Daughter)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3752 Colliers Drive/Edgewater MD 21037</b>   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria VA</b>  |  |
| 20d. Date<br><b>2/8/2011</b>   |  | 21. Signature of Funeral Service Licensee<br><i>Melanie T. H. ...</i>  |  | 22. Name and Address of Facility<br><b>Advent Funeral &amp; Cremation Services</b><br><b>Annapolis MD, Falls Church VA</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Dementia</b>  |  |  |  |  |  |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>RUTHERFORD MANOR</b>  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br><i>Michael J. LaPenta</i>   |  | 29c. License number<br><b>D 21438</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>February 07 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL J. LA PENTA 441 DEFENSE HWY ANNAPOLIS MD 21401</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br><i>Anna B. ...</i>  |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05865

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Mae Christian

2. Date of Death

February 6, 2011

3. Time of Death

5:27 p.m.

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-26-7748

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 11, 1922

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1200 Delaware Ave. S.W.

10f. Zip Code

20024

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Custodial Maid

16b. Kind of Business Industry

Private

17. Father's Name (First, Middle, Last)

Robert Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Ella Kelton

19a. Informant's Name/Relationship (Type, Print)

Paul Riggins / Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

170-35th Street N.E. Washington, D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln

Date

2/11/2011

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

Alexander S. Pope

22. Name and Address of Facility

5538 Marlboro Pike/ Forestville, Md. 20747

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

ACUTE MYOCARDIAL INFARCTION

b. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

HYPERCHOLESTEROLEMIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. JODRIE

29c. License number

D40324

29d. Date signed (Month, Day, Year)

FEBRUARY 8, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRY JODRIE, MD, FACEP 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

L. J. JODRIE

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 30 per DVR 6912 2/25/11  
State of Maryland / Department of Health and Mental Hygiene

05866

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Robert Chapla</b>  |  | 2. Date of Death<br>Month <b>02</b> Day <b>14</b> Year <b>11</b>  |  | 3. Time of Death<br><b>1308</b> M   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>  |  |
| 5. Social Security Number<br><b>030-22-5156</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>81</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 8, 1929</b> | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>  |  |
| Usual Residence of Decedent  |  |   |  |   |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Hagerstown</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>13409 Windsor Drive</b>   |  | 10f. Zip Code<br><b>21742</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Finance</b>  |  |
| 16b. Kind of Business Industry<br><b>U.S. Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph William Chapla</b>   |  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Ann O'Brian</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Timothy Chapla / Son</b>   |  |   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13409 Windsor Drive, Hagerstown, MD 21742</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  | 20c. Date<br><b>2/21/2011</b>   |  | 20d. Location - City or Town, State<br><b>Smithsburg, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Rest Haven Funeral Chapel</b><br><b>1601 Pennsylvania Ave., Hagerstown, MD 21742</b>   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac Arrest</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>&gt;30 years</b>  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown  |  |   |  |   |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Prostate Cancer</b>   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Thomas Michael White MD</b>  |  | 29c. License number<br><b>A0067581</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02/16/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas White MD 251 E Antietam Street, Hagerstown MD 21740</b>  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br>   |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

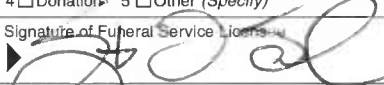


State of Maryland / Department of Health and Mental Hygiene

2011 05867

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |                                 |   |  |  |  |   |   |  |  |
|--|---|---------------------------------|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JULIA MARIE COVERT</b>   |                                 |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>15</b> Year <b>2011</b>   |  |   |   | 3. Time of Death<br><b>5:30 a<sup>M</sup></b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Smith Creek Assisted Living</b>  |                                 |   |  | 4b. City, Town, or Location of Death<br><b>Warwick</b>   |  |   |   | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>207-26-3208</b>   |                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 23 1934</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                    |  |
|  | Usual Residence of Decedent   |                                 |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |                                 | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Ocean Pines</b>  |  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>40 Watergreen Lane</b>   |                                 |   |  | 10f. Zip Code<br><b>21811</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |                                 |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waitress</b>   |  |   | 16b. Kind of Business/Industry<br><b>Food Service</b>                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Raymond Cotumaccio</b>   |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Veronica Carrigan</b>   |  |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>George W. Covert (husband)</b>   |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>40 Watergreen Lane Ocean Pines, MD. 21811</b>  |  |   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cem.</b>  |  | Date<br><b>2/21/11</b>   |  | 20c. Location - City or Town, State<br><b>Yeadon, PA.</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br> <b>M00510</b>  |                                 |   |  | 22. Name and Address of Facility<br><b>Galena Funeral Home of Stephen L Schaech<br/>118 West Cross St. Galena, MD. 21635</b>   |  |   |   |  |  |
|  | 23a. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Dementia</b>                   |                                 |   |  |  |  |   |   |  |  |
|  | 23b. Immediate Cause (Final disease or condition resulting in death)<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):                |                                 |   |  |  |  |   |   |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   |                                 |   |  |  |  |   |   |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |                                 |   |  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                 |   |  |  |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |                                 |   |  |  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                 |   |  |  |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                                 |   |  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                 |   |  |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>   |   |                                 |   |  |  |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                                 |   |  |  |  |   |   |  |  |
| 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                 |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                 |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>   |   |                                 |   | 29c. License number<br><b>D0023322</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2.15.2011.</b>                     |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sheelmohan S. Sachdev, M.D. 126 E. High St. Elkton, MD. 21921</b>   |   |                                 |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |   |                                 |   |  |  |  |   |   |  |  |
| 32. Registrar's Signature<br>   |   |                                 |   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For  
State  
Registrar

Amend Items

State of Maryland / Department of Health and Mental Hygiene  
24a, 25 per dr., 02/25/2011  
Certificate of Death

Reg. No.

2011 05868

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Anthony Diorio, Sr.

2. Date of Death

February 12 2011

3. Time of Death

2:10 PM

4a. Facility Name (if not institution, give street and number)

Meritus Health Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

133-26-9225

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

8. Date of Birth

April 11, 1934

9. Birthplace (State or foreign country)

New York

10. Usual Residence of Decedent

Berkeley Springs

11. Marital Status

1 ☐ Never Married 2 ☒ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

10a. State

WV

10b. County

Morgan

10c. City, Town or Location

Berkeley Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

52 Bennett Lane, P.O. Box 24

10f. Zip Code

25411

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

C-1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Broker

16b. Kind of Business Industry

Ships

17. Father's Name (First, Middle, Last)

Vincent J. Diorio, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Merie C. Hohenstein

19a. Informant's Name/Relationship (Type, Print)

Doris Ann Diorio- Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 24, Berkeley Springs, WV 25411

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hagerstown Crematory

Date

Feb. 14, 2011

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

Doris C. Samsel

M00522

22. Name and Address of Facility

Berkeley Springs, WV 25411

Helsley-Johnson FH &amp; Cremation Center, 95 Union St.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Pneumonia / Respiratory Failure

Due to (or as a consequence of):

b. Abdominal Aortic Aneurysm

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Doris C. Samsel

29c. License number

D0038764

29d. Date signed (Month, Day, Year)

2/14/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen R. Zibbe, MD 1110 Medical Campus Rd STE 129 Hagerstown MD 21742

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Doris C. Samsel

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

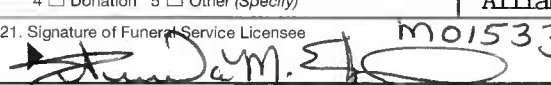
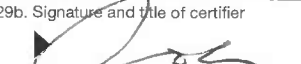

2011 05869

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Finis W. Dailey</b>  |  |  |  | 2. Date of Death<br>Month <b>Feb</b> 8, 2011 Day Year  |  | 3. Time of Death<br><b>6:35 A</b> M   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Fort Washington Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Fort Washington</b>   |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| 5. Social Security Number<br><b>293 50 2163</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 15, 1950</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |  |  |  |  |  |   |  |
| Usual Residence of Decedent   |  |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Fort Washington</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>13311 Washington Drive</b>   |  |  |  | 10f. Zip Code<br><b>20744</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>8</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>   |  | 16b. Kind of Business Industry<br><b>American Chemical Society</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Garfield Dailey</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Inez Payton</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Adele Smith Dailey (Wife)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13311 Washington Drive, Fort Washington, MD 20744</b>  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Alliance Cemetery</b>   |  | Date<br><b>Feb 14, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Alliance, Ohio</b>  |  |
| 21. Signature of Funeral Service Licensee<br> <b>MO1533</b>  |  |  |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735</b>   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>Arteriosclerosis</b><br>Due to (or as a consequence of):<br>c. <b>Atherosclerosis</b><br>Due to (or as a consequence of):<br>d. <b>Coronary artery disease</b><br>Due to (or as a consequence of):   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  |  |  |  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>00065385</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/8/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alex Rosin, M.D. 11711 Livingston Road, Fort Washington, MD 20744-5164</b>   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |  |  |  | 32. Registrar's Signature<br>   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

KB10

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05870

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Quincy Davis

2. Date of Death

02 Month 05 Day 2011 Year

3. Time of Death

1:02 A M

4a. Facility Name (if not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

245-68-4369

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

65 Yrs.

8. Date of Birth

03/24/1945

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

304 Corla Drive

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. 1976-1982

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Special Police Officer

16b. Kind of Business Industry

National Gallery of Art

17. Father's Name (First, Middle, Last)

William Davis

18. Mother's Name (First, Middle, Maiden Surname)

Sallie E. McCormick

19a. Informant's Name/Relationship (Type, Print)

Gale Carroll-Davis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 Corla Drive Oxon Hill, MD 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veteran's Cemetery

Date

02/16/2011

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Nyah Frederick

22. Name and Address of Facility

Marshall-March Funeral Home  
4308 Suitland Road Suitland, MD 20746Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

COLON CANCER

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

CORONARY DISEASE

b. Due to (or as a consequence of):

DIABETES

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nyah Frederick

29c. License number

D0057518

29d. Date signed (Month, Day, Year)

2/8/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIEN NGUYEN 6104 Old Branch Avenue Temple Hills, MD 20748

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Liana S. Sparks

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05871

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rev. John T. Doyle, O.S.F.S.

2. Date of Death

Month Day Year  
February 14 2011

3. Time of Death

0800 A M

4a. Facility Name (if not institution, give street and number)

Annecy Hall

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

192-16-5135

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
NOV 29, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1120 Blue Ball Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5+ College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Priest/Educator

16b. Kind of Business Industry

Religion

17. Father's Name (First, Middle, Last)

John T. Doyle

18. Mother's Name (First, Middle, Maiden Surname)

Marie Lawlor

19a. Informant's Name/Relationship (Type, Print)

Oblates of St. Francis de Sales

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2200 Kentmere Parkway, Wilmington, DE 19806

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oblate Cemetery

Date

February 19, 2011

20c. Location - City or Town, State

Childs, MD

21. Signature of Funeral Service Licensee

Donald S. Hicks

22. Name and Address of Facility

Hicks Home for Funerals, P.A.

103 W. Stockton Street, Elkton, MD 21921

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Debility

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Millerand, MD

29c. License number

D56979

29d. Date signed (Month, Day, Year)

2/14/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Madai Chardon 617 Stemmers Run RD, Balto, 21221

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Don S. Hicks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

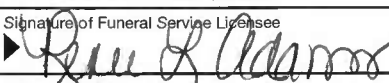
1- For  
State  
Registrar

## Certificate of Death

Reg. No.

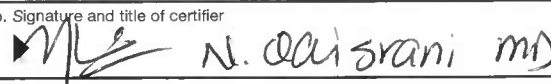
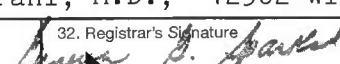
Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Albert Eugene Earnest   |  |   |  | 2. Date of Death<br>Month 2 Day 3 Year 11  |  | 3. Time of Death<br>1835 M   |  |
| 4a. Facility Name (if not institution, give street and number)<br>Western MD Regional Medical Center  |  |   |  | 4b. City, Town, or Location of Death<br>Cumberland   |  | 4c. County of Death<br>Allegany  |  |
| 5. Social Security Number<br>220-10-8720  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>06/20/1919  |  |
| 9. Birthplace (State or Foreign Country)<br>Maryland  |  | Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br>MD  |  | 10b. County<br>Allegany   |  | 10c. City, Town or Location<br>Cumberland  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>100 Columbia Street   |  | 10f. Zip Code<br>21502  |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                                  |  | 16b. Kind of Business Industry<br>Petroleum  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Albert Ernest  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lottie Viola Emerick  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ken A. Earnest / Son  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9632 Groveland Street, Seminole, FL 33772   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cumberland Crematory  |  | Date<br>02/07/2011   |  | 20c. Location - City or Town, State<br>Cumberland, MD  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502  |  |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE RENAL FAILURE<br>Due to (or as a consequence of):<br>b. ALCOHOL ABUSE<br>Due to (or as a consequence of):<br>c. HYPOTENSIVE SHOCK<br>Due to (or as a consequence of):<br>d. _____   |  |   |  | Approximate Interval Between Onset and Death   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION, HYPOTHYROIDISM   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br> N. Qaisrani MD  |  | 29c. License number<br>D0064167   |  | 29d. Date signed (Month, Day, Year)<br>2/4/11  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Noshin Qaisrani, M.D., 12502 Willowbrook Road, Cumberland, MD 21502  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 04 2011   |  | 32. Registrar's Signature<br>  |  |  |  |

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05873

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth S. Ellis

2. Date of Death

February 7, 2011

3. Time of Death

11:30 a

4a. Facility Name (if not institution, give street and number)

30374 Calhoun Ave.

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

213-22-9745

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04/18/1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30374 Calhoun Ave.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

office assistant

16b. Kind of Business Industry

automotive

17. Father's Name (First, Middle, Last)

Emory Smith

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Harrington

19a. Informant's Name/Relationship (Type, Print)

Dorothy Baker/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 25, Delmar, DE 19940

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stephens Cemetery

Date

2/11/2011

20c. Location - City or Town, State

Delmar, DE

21. Signature of Funeral Service Licensee

Holloway Funeral Home Professional Association

22. Name and Address of Facility

501 Snow Hill Rd., Salisbury, MD 21804

Physician/  
Medical  
Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cdiff hyperlipidemia  
Wegner's  
Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elleda Ziemer

29c. License number

H0061327

29d. Date signed (Month, Day, Year)

2/10/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elleda Ziemer, M.D. 100 Power St., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Lynn S. Jones

State  
RegistrarTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 Amend Item 8 per 11,8913,03/22/2011  
 Certificate of Death  
 2011 05874  
 Reg. No.

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph F Ellsworth, Jr.</b>   |  |   |  | 2. Date of Death<br>Month <b>Feb</b> Day <b>18</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>1:20 P M</b>  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>VA Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>MD</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-54-7046</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>10/24/1948</b><br><del>Aug 24, 1948</del>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>203 Baltimore Ave. Apt. A</b>  |  | 10f. Zip Code<br><b>21222</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. <b>Vietnam</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>van driver</b>  |  | 16b. Kind of Business Industry<br><b>PTI</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph F. Ellsworth, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen (Herrell) VanHorn</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Ellsworth wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>203 Baltimore Ave. Apt. A Dundalk MD 21222</b>  |  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rocky Gap Veterans Cemetery</b>  |  | Date<br><b>2/23/2011</b>  |  | 20c. Location - City or Town, State<br><b>Flintstone MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home, PA<br/>108 Virginia Avenue, Cumberland, MD 21502</b>   |  |   |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>septic shock</b><br>Due to (or as a consequence of):<br>b. <b>intestinal perforation</b><br>Due to (or as a consequence of):<br>c. <b>metastatic lung cancer</b><br>Due to (or as a consequence of):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>7 days</b><br><b>2 months</b> |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D64246</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Feb 18 2011</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kimberly Lumpkins 10 N. Greene St Baltimore MD 21201</b>  |  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br>  |   |  |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05875

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |  |  |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Grace Rice Franklin   |  |   |  | 2. Date of Death<br>Month Day Year<br>February 6, 2011   |  |   |  | 3. Time of Death<br>11:30A M   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>7165 Glen Albin Drive   |  |   |  | 4b. City, Town, or Location of Death<br>La Plata   |  |   |  | 4c. County of Death<br>Charles   |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-24-0775  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 13, 1925     |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  |  | 10b. County<br>Charles  |  | 10c. City, Town or Location<br>La Plata  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>7165 Glen Albin Drive   |  |   |  | 10f. Zip Code<br>20646   |  |   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Office Manager  |  |   |  | 16b. Kind of Business Industry<br>Oil Company  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Jarrett Webster Rice   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Olive Mae Rice  |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>David Franklin/Son  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 143, Newburg, MD 20664   |  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dentsville Methodist  |  | Date<br>2/10/2011  |  | 20c. Location - City or Town, State<br>La Plata, Maryland |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>David C. Echols  |  |   |  | 22. Name and Address of Facility<br>AREHART-ECHOLS FUNERAL HOME, P.A.<br>211 St. Mary's Ave. La Plata, MD 20646  |  |   |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>b. DIABETES MELLITUS<br>Due to (or as a consequence of):<br>c. Congestive Heart Failure<br>Due to (or as a consequence of):<br>d. |  |   |  |  |  |   |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |   |  |   |  |  |  |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |  |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   |  |  |  |   |  |  |  |
| 28a. Date of injury (Month, Day, Year)   |   |  |   |  |  |  |   |  |  |  |
| 28b. Time of injury<br>M   |   |  |   |  |  |  |   |  |  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |  |   |  |  |  |
| 28d. Describe how injury occurred  |   |  |   |  |  |  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |  |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>George A. Wathen  |   |  |   |  |  |  |   |  |  |  |
| 29c. License number<br>D20629  |   |  |   |  |  |  |   |  |  |  |
| 29d. Date signed (Month, Day, Year)<br>2/7/11  |   |  |   |  |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>GEORGE A. WATHEN MD. WADSWORTH, MD 20603.  |   |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 11 2011   |   |  |   |  |  |  |   |  |  |  |
| 32. Registrar's Signature<br>Anna B. Sparks  |   |  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

NB6

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

2011 05876

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte (Miller) Freeland

2. Date of Death  
Month Day Year2 13 11 1055<sup>M</sup>

3. Time of Death

4a. Facility Name (if not institution, give street and number)

WMHS-RMC

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

214-05-5262

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)

Jul 6, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

730 Furnace Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: white15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

Elmer Miller

18. Mother's Name (First, Middle, Maiden Surname)

Lillie (Wiegand) Miller

19a. Informant's Name/Relationship (Type, Print)

Carol Andrews

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10105 Shortest Day Road LaVale

MD 21502

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Zion Reformed Church Cemetery

Date

2/16/2011

20c. Location - City or Town, State

Cumberland

MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA

108 Virginia Avenue, Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

Endstage Aortic Valve stenosis

Approximate  
Interval Between  
Onset and Death

New year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hm Suu

29c. License number

D46346

29d. Date signed (Month, Day, Year)

2/14/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUMA SHAKIL M.D. 675 KENT AVE. STE. 204 CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Diana D. Sparks

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.




State of Maryland / Department of Health and Mental Hygiene

2011 05877

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |   |   |   |  |   |
|--|---|---|---|---|---|--|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Cecelia Goddard</b>   |   |   | 2. Date of Death<br>Month Day Year<br><b>February 11, 2011</b>  |   | 3. Time of Death<br><b>7:50 a.m.</b>   |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Mary's Nursing Center</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>  |   | 4c. County of Death<br><b>St. Mary's</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-22-0976</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>84</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>11/23/1926</b>                |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Leonardtown</b>                       |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>23255 Hollywood Road</b>   |   | 10f. Zip Code<br><b>20650</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Draft Board Clerk</b>                 |   | 16b. Kind of Business Industry<br><b>County Government</b>  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>R. Woodley Goddard</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Maria Coates</b>  |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Judy Bakewell/Daughter</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 469, Leonardtown, MD 20650</b> |   |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Aloysius Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Leonardtown, MD</b>   |  |   |
|  | 21. Signature of Funeral Service Licensee<br><br><b>Edward N. Brinsfield, Jr. M00052</b>   |   | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>                              |   |   |  |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ADVANCED ALZHEIMER'S DEMENTIA</b>  |   |   |   |   |  |   |
|  | 23b. Part 2. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |   |   |   |   |  |   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |   |   |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M  |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><br><b>MD</b>   |   | 29c. License number<br><b>DJ60-96</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2-14-11</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LARRY DORR S. GIL MD SMITH ASSOCIATES HOLLYWOOD MD</b>  |   |   |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 15 2011</b>  |   | 32. Registrar's Signature<br>  |   |   |   |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05878

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larry James Grossnickle

2. Date of Death

02<sup>Month</sup> 04<sup>Day</sup> 2011<sup>Year</sup>

3. Time of Death

1:15 P<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Kline Hospice House

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Frederick

5. Social Security Number

217-58-3312

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month Day Year)

9/12/1949

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9051 Harmony Rd.

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

17. Father's Name (First, Middle, Last)

James P. Grossnickle

18. Mother's Name (First, Middle, Maiden Surname)

Esther Reid

19a. Informant's Name/Relationship (Type, Print)

Muriel Grossnickle (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9051 Harmony Rd., Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of Cemetery, Church, or other place)

Grossnickle

Cemetery

Date

2/8/2011

20c. Location - City or Town, State

Myersville, MD

21. Signature of Funeral Service Provider

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
POB 18, Middletown, MD 21769

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Weeks

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D68104

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

516 Trail Ave, Frederick, MD 21702

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|   |  |                              |
|---|--|------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br>Lawrence Darnelle Garner, Jr. | 2. Date of Death<br>Month Day Year<br>February 7, 2011 | 3. Time of Death<br>2257 hrs |
|---|--|------------------------------|

Funeral  
Director

|  |  |   |
|--|--|---|
| 4a. Facility Name (if not institution, give street and number)<br>Southern Maryland Hospital | 4b. City, Town, or Location of Death<br>Clinton                                | 4c. County of Death<br>Prince George's    |
| 5. Social Security Number<br>578-23-4351   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>18 Yrs. |
| 8. Date of Birth (MM/DD/YYYY)<br>07/23/1992  | 9. Birthplace (State or Foreign Country)<br>MD                                 |   |

To Be Completed by Funeral Director

|  |                                |   |  |
|--|--------------------------------|---|--|
| 10a. State<br>MD                             | 10b. County<br>Prince George's | 10c. City, Town or Location<br>Brandywine | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 10e. Street and Number<br>8707 Sheehan Drive |                                | 10f. Zip Code<br>20613                    | 10g. Citizen of What Country?<br>USA   |

|  |   |  |  |
|--|---|--|--|
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+)   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk                                    | 16b. Kind of Business/Industry<br>Home Depot   |  |

|  |  |
|--|--|
| 17. Father's Name (First, Middle, Last)<br>Lawrence Darnelle Garner, Sr. | 18. Mother's Name (First, Middle, Maiden Surname)<br>Charlane Campbell |
|--|--|

|  |  |
|--|--|
| 19a. Informant's Name/Relationship (Type, Print)<br>Lawrence D. Garner, Sr./Father | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8707 Sheehan Drive Brandywine, MD 20613 |
|--|--|

|  |   |  |
|--|---|--|
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify: | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resurrection Cemetery | 20c. Location - City or Town, State<br>Clinton, MD |
|--|---|--|

|  |  |
|--|--|
| 21. Signature of Funeral Service Licensee<br><i>Mark Frederick</i> | 22. Name and Address of Facility<br>Marshall-March Funeral Home<br>4308 Suitland Road Suitland, MD 20746 |
|--|--|

Baltimore, MD 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical Examiner

|  |  |  |
|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><input type="checkbox"/> UNPENDED <input type="checkbox"/> AMENDED | a. Multiple Injuries<br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. | Approximate Interval Between Onset and Death |
|--|--|--|

|  |   |   |
|--|---|---|
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown | 23d. Date of delivery<br>Month Day Year |
|--|---|---|

|  |  |
|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br> | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other: |
|---|---|

|   |  |                                 |  |   |
|---|--|---------------------------------|--|---|
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide | 28a. Date of Injury (Month, Day, Year)<br>Feb 7, 2011  | 28b. Time of Injury<br>2156 hrs | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                | 28d. Describe how injury occurred<br>Driver of motor vehicle involved in collision with another vehicle |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc.<br>(Specify) Major Road / Highway |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>10700 Block of North Keys Road, Brandywine, MD |   |

|   |   |                                 |   |
|---|---|---------------------------------|---|
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br><i>Patricia Aronica Pollak</i> | 29c. License number<br>O.C.M.E. | 29d. Date signed (Month, Day, Year)<br>February 9, 2011 |
|---|---|---------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a)<br>Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 |
|---|

State  
Registrar

|  |   |
|--|---|
| 31. Date filed (Month, Day, Year)<br>FEB 14 2011 | 32. Registrar's Signature<br><i>Patricia Aronica-Pollak</i> |
|--|---|

Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05880

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Judith

Lee

Godlove

2. Date of Death

February 15, 2011

3. Time of Death

0218 A M

4a. Facility Name (if not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

217-30-6449

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

8. Date of Birth

March 2, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 W. Baltimore St. Apt. 915

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Domestic

17. Father's Name (First, Middle, Last)

Preston T. Martin

18. Mother's Name (First, Middle, Maiden Surname)

Julia L. Snyder

19a. Informant's Name/Relationship (Type, Print)

Jerry S. Godlove/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 W. Baltimore St. Apt. 915, Hagerstown, MD 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

2/16/2011

20c. Location - City or Town, State

Smithsburg, MD

21. Signature of Funeral Service Licensee

S. Mark Sings

22. Name and Address of Facility

Rest Haven Funeral Chapel  
1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute respiratory failure  
Due to (or as a consequence of):b. Chronic obstructive pulmonary disease  
Due to (or as a consequence of):c. Lung cancer  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

V. P. Hospitalist

29c. License number

D 0059414

29d. Date signed (Month, Day, Year)

02/15/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vladimir Rakhmanin, MD 1116 Medical Campus Rd. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Dana A. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05881

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roger D. Griest

2. Date of Death

Month Day Year  
Feb. 17, 2011

3. Time of Death

10:30 P<sup>M</sup>Funeral  
Director

4a. Facility Name (If not institution, give street and number)

16819 Gorsuch Mill Road

4b. City, Town, or Location of Death

Upperco

4c. County of Death

Baltimore

5. Social Security Number

218-32-3075

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 30, 1935

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Upperco

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16819 Gorsuch Mill Road

10f. Zip Code

21155

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1956 - 195813. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Preacher

16b. Kind of Business/Industry

Clergy

17. Father's Name (First, Middle, Last)

Walter Griest

18. Mother's Name (First, Middle, Maiden Surname)

Mary Steele

19a. Informant's Name/Relationship (Type, Print)

Jeffrey J. Griest/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

603 W. 33rd St. Baltimore, MD 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Mt. Carmel  
United Methodist

Date

Feb. 25  
2011

20c. Location - City or Town, State

Parkton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 N. Second St., New Freedom, PA 1734923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Due to (or as a consequence of):  
MULTIPLE MYELOMAApproximate  
Interval Between  
Onset and Death

1 yr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
Bladder cancer

1 yr

c. Due to (or as a consequence of):  
Diabetes Mellitusd. Due to (or as a consequence of):  
Normal pressure hydrocephalus

1-2 yrs

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CABG and Heart disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19153

29d. Date signed (Month, Day, Year)

2/18/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK J. KARLAV MD 16921 York Rd. Monkton Md 21111

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05882

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elisabeth Herberg</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>11</b> , Year <b>2011</b>   |  | 3. Time of Death<br><b>5:43 A<sup>M</sup></b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>24435 Hollywood Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Hollywood</b>   |  | 4c. County of Death<br><b>St. Mary's</b>  |  |
| 5. Social Security Number<br><b>217-34-2162</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>March 21, 1920</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>   |  | 10c. City, Town or Location<br><b>Hollywood</b>   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>24435 Hollywood Road</b>  |  | 10f. Zip Code<br><b>20636</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Johan Beyer</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Barton</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Reinhold Herberg / Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5934 Serenity Lane, Derwood, MD 20855</b>   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Leonardtown, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>  |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, MD 20650</b>  |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br>a. <b>Pneumonia</b><br>b. <b>CHF, Peripheral Vascular Disease</b><br>c. <b>Coronary artery Disease</b><br>d. <b>Coronary artery Disease</b>   |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)                      |  | 23d. Date of delivery<br>Month Day Year   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of injury (Month, Day, Year)<br><b>M</b>  |  |
| 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - If in home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><i>James C. Boyd</i>  |  | 29c. License number<br><b>D19916</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/14/11</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James C. Boyd MD<br/>41680 Bessie Drive Ste 301 Leonardtown, Maryland 20650</b>   |  | 31. Date filed (Month, Day, Year)<br><b>FEB 14 2011</b>  |  | 32. Registrar's Signature<br><i>Sharon B. Sparks</i>  |  |

1- For State Registrar

Reg. No.

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Henry Rowe Hipsley</b>  |  | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>10:35 p M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Gilchrist Hospice Care</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>216-16-1447</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>87</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>04/06/1923</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
| Usual Residence of Decedent  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>St. Mary's</b>   | 10c. City, Town or Location<br><b>Bushwood</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>37035 Willie Cheseldine Road</b>  |  | 10f. Zip Code<br><b>20618</b>  |  | 10g. Citizen of What Country?<br><b>U S A</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> <del>Never Married</del> <input checked="" type="checkbox"/> <del>Married</del> <input type="checkbox"/> <del>Widowed</del> <input type="checkbox"/> <del>Divorced</del>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Claims Manager</b>   |  | 16b. Kind of Business Industry<br><b>Insurance Company</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Hipsley</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hilda Shreeve</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Steven Hipsley/Son</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8500 Bethany Court, Vienna, VA 22182</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge</b>   |  | 20c. Location - City or Town, State<br><b>02/09/2011 Pikesville, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Danielle Ward MD1403</b>   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>sepsis</b>  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>days</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |
| 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute renal failure, congestive heart failure, Diabetes mellitus</b>  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>hospice</b> |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of injury<br>M <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D58303</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 10 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Arnon J. Charles MD 6701 N. Charles St Towson MD</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 15 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05884

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Patrick Holt

2. Date of Death

February 3 2011

3. Time of Death

6:36 PM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

579-86-1478

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 18, 1957

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

101 Capricorn Drive

10f. Zip Code

21793

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. 1976

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business Industry

Printing Services

17. Father's Name (First, Middle, Last)

George Homer Holt

18. Mother's Name (First, Middle, Maiden Surname)

Jane Louise Spangler

19a. Informant's Name/Relationship (Type, Print)

Carrieanne Holt / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

c/o Caroline Atkins, Front Royal, VA 22630

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenmount Crematory

Date

Feb. 8, 2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Resthaven Funeral Services, Skkot Cody P.A., 9501 Catoctin Mountain Hwy. Frederick, MD 21701

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Cardiac arrhythmia

b. Due to (or as a consequence of):

ASCD

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sigmoid diverticulitis with abscess

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MDD 35267

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manuel A. Casiano, 400 W 14th St, Frederick, MD 21701

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+ IVA

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05885

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Debra Lynn Hudgins</b>  |  |   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>6,</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>3:03am</b> M  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  | 4c. County of Death<br><b>Carroll</b>  |  |
| 5. Social Security Number<br><b>220-54-8797</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/29/1958</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |  | Usual Residence of Decedent   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Hampstead</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1556 Fairmount Road</b>   |  |   |  | 10f. Zip Code<br><b>21074</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pharmacy technician</b>  |  | 16b. Kind of Business Industry<br><b>Pharmacy</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alvin Curtis</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Reed</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Daniel Menchey, son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4296 Sycamore Drive, Hampstead, MD 21074</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hampstead Cemetery</b>   |  | Date<br><b>2/11/2011</b>   |  | 20c. Location - City or Town, State<br><b>Hampstead, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Paula L. Lemmer</b> M00741   |  | 22. Name and Address of Facility<br><b>Eline Funeral Home</b><br><b>934 S. Main Street, Hampstead, MD 21074</b>   |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>metastatic breast cancer</b><br>Due to (or as a consequence of):<br>a. <b>metastatic breast cancer</b><br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  | Approximate Interval Between Onset and Death   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>GERD</b><br><b>Coronary artery</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Ernesto Mendoza</b>   |  | 29c. License number<br><b>00050763</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/7/11</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ernesto Mendoza, M.D., 200 Memorial Ave., Westminster, Md. 21157</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br><b>Anna B. Spaw</b>  |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 05886


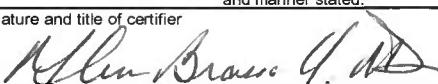

State of Maryland / Department of Health and Mental Hygiene

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Michele Finesse Hughes</b>   |  | 2. Date of Death<br>Month Day Year<br><b>February 5, 2011</b>  |  | 3. Time of Death<br><b>2249 hrs</b>  |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Hospital Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  | 4c. County of Death<br><b>Carroll</b>  |   |
| 5. Social Security Number<br><b>214-82-6225</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.   | 8. Date of Birth (MM/DD/YYYY)<br><b>01/01/1961</b>                         |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
| Usual Residence of Decedent   |  |  |  |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Carroll</b>  | 10c. City, Town or Location<br><b>Westminster</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>2612 Neudecker Road</b>  |  | 10f. Zip Code<br><b>21157</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No specify: |   |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |  |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Joseph Coleman</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shirley Ludwig</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark Allen Hughes/husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2612 Neudecker Road, Westminster, MD 21157</b>   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other Specify:  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen Mem. Gard.</b>  |  | 20c. Location - City or Town, State<br><b>2/10/2011 Finksburg, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home &amp; Chapel<br/>412 Washington Road, Westminster, MD 21157</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><input type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED <b>Item 4b per M.E. 2/8/11 Carroll County, wjl</b> |  |  |  |  | Approximate Interval Between Onset and Death  |
| 23b. If female, Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown  |  |  |  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br><input type="checkbox"/> Unknown                 |
| 23d. Date of delivery<br>Month Day Year   |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other: |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>Feb 5, 2011</b>   |  | 28b. Time of Injury<br><b>2159 hrs</b>   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Subject driver of vehicle left roadway striking tree</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Local Street</b>  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Houck Road and Jocks Drive, Westminster, MD</b>  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. Signature and title of certifier<br><br><b>Melissa Brassell, MD Assistant Medical Examiner</b>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>February 6, 2011</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a)<br><b>Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223</b>   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 2011</b>   |  | 32. Registrar's Signature<br>   |  |  |   |

Baltimore, MD 21215-0036  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical ExaminerPhysician/  
Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY D. HAWKINS</b>  |   | 2. Date of Death<br>Month <b>2</b> Day <b>3</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>1850</b> M  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Ginger Cove Health Center</b>   |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-46-5965</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  | 8. Date of Birth<br>Month <b>10</b> Day <b>31</b> Year <b>1915</b> | 9. Birthplace (State or Foreign)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Anne Arundel</b>  | 10c. City, Town or Location<br><b>Annapolis</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>4000 River Crescent Drive</b>   |   | 10f. Zip Code<br><b>21401</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>           |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   | 16b. Kind of Business Industry<br><b>Own Home</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Fenwick Leatherburg Lyons</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Russell</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Roblyer - Attorney</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Willow St, Annapolis, MD 21401</b>              |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Michael T. Keohat</b>  |   | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home</b><br><b>147 Duke of Gloucester St, Annapolis, MD 21401</b>                       |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CEREBROVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><b>DEMENTIA</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension, D.M.</b> |   |   |  |  |
| 23b. If FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, D.M.</b>   |  |   |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br>M<br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier<br>(Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input checked="" type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>G.L. Taylor</b>   |  | 29c. License number<br><b>R118703</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2/4/2011</b>             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GENEVIEVE LIGHTFOOT-TAYLOR, 445 DEFENSE HWY, ANNAPOLIS, MD 21401</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |  | 32. Registrar's Signature<br><b>Bernard A. Sparks</b>   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #12 Per med cert G912 2/24/11

State of Maryland / Department of Health and Mental Hygiene

amend #12 Per FH G913 3/10/2011 TH

Reg. No.

2011 05888

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Francis William Hartzell

2. Date of Death

February 13, 2011

3. Time of Death

3:00 AM

4a. Facility Name (if not institution, give street and number)

7431 Willow Road, Cottage 13

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

190-18-4024

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

87

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

August 11, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7431 Willow Road, Cottage 13

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☒ No

If Yes, Give Year or Dates. '42-'46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Corporation Director

16b. Kind of Business Industry

Professional Development

17. Father's Name (First, Middle, Last)

Richard Franklin Hartzell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Ann Springer

19a. Informant's Name/Relationship (Type, Print)

Margaret Hartzell / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7431 Willow Rd, Cottage 13, Frederick, MD 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Smithsburg Crematory

Date

February

14, 2011

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

[Signature]

MO1473

22. Name and Address of Facility

Keeney and Basford PA Funeral Home

106 E. Church Street, Frederick, MD 21701

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC ADENOCARCINOMA OF COLON

Approximate Interval Between Onset and Death

8 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Brian M. O'Connor, MD

29c. License number

P31761

29d. Date signed (Month, Day, Year)

2/14/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN M. O'CONNOR MD 501 W. SEVENTH ST. FREDERICK, MD 21701

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05889

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GENEVIEVE E. HAYES</b>  |   |   | 2. Date of Death<br>Month Day Year<br><b>FEB. 13 2011</b>   |  | 3. Time of Death<br><b>9:35P M</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>362 OLD MILL RD.</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Conowingo</b>  |  | 4c. County of Death<br><b>Cecil</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>195-14-3540</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>July 17, 1923</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>   |   |  |
|   | Usual Residence of Decedent  |   |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Cecil</b>  |   |  |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br><b>Conowingo</b>  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |
|   | 10e. Street and Number<br><b>362 Old Mill Rd.</b>  |   |   | 10f. Zip Code<br><b>21918</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Karol Rrucidlo</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth (unknown)</b>   |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald Hayes/son</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>362 Old Mill Rd. Conowingo, MD. 21918</b> |  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Family Cremation Service</b>   |   | 20c. Location - City or Town, State<br><b>Feb. 16, 2011 Wilm., De.</b>   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>Cremation Service Of Delaware</b>  |   | 23. Date of Facility<br><b>519 Phila. Pike Wilm., De. 19809</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic lymphoma</b> |   |   |   |  |  |   |  |
|   | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.                 |   |   |   |  |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death<br><input type="checkbox"/> Pregnant at time of death<br><input type="checkbox"/> Unknown   |   | 23d. Date of delivery<br>Month Day Year   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Son's home</b> |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>D56979</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/14/2011</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Madam Chardon 617 Stemmers Run RD, Ba No, 21221</b>  |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Reg. No.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie James

2. Date of Death  
Month Day Year  
February 2, 20113. Time of Death  
5:09 A MFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Wicomico Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

219-07-7750

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 2, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Wicomico

10c. City, Town or Location

Tyaskin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22591 Capitola Road

10f. Zip Code

21865

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Coldwater Seafood

17. Father's Name (First, Middle, Last)

Ora Dashiell

18. Mother's Name (First, Middle, Maiden Surname)

Nancy Conway

19a. Informant's Name/Relationship (Type, Print)

Lionel James/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 Dorsey Lane - Salisbury, Maryland 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

John Wesley UMC Cemetery

Date

Feb. 12, 2011 Whitehaven, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Salisbury, Maryland  
Jolley Memorial Chapel - 1213 Jersey Road 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D63191

29d. Date signed (Month, Day, Year)

2/11/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YOGESHA VOHRA 910 EASTERN SHORE DR., SALISBURY, MD, 21804

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05892

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Marie Johnson

2. Date of Death

February 6, 2011

3. Time of Death

1:05 p<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

5. Social Security Number

579-54-2768

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 7, 1941

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8601 Temple Hills RD.

10f. Zip Code

20748

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business Industry

D.C. Public Schools

17. Father's Name (First, Middle, Last)

Elmer D. Johnson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lane

19a. Informant's Name/Relationship (Type, Print)

Tijuanna Woods / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8601 Temple Hills Rd. #90 Temple Hills, Md. 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial

Date

2/11/2011

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

Beth A. Dunge, 0101085

22. Name and Address of Facility

Alexander S. Pope, P.A. 5538 Marlboro Pike/ Forestville, Md. 20747

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic breast cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

encephalopathy, thrombocytopenia, anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Varsha Vanikar, MD

29c. License number

D0064289

29d. Date signed (Month, Day, Year)

02/08/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Varsha Vanikar 7503 Surratts Rd. Clinton, Md 20735

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

A. J. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05893

1- For State Registrar Amend #26 per PHYS 2/9/11 Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CLARENCE EDWARD JASPER

2. Date of Death

Month Day Year  
FEB. 5, 2011

3. Time of Death

6:45 P<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

9303 MANNY FLOWERS LANE

4b. City, Town, or Location of Death

JESSUP

4c. County of Death

HOWARD

5. Social Security Number

226-54-0841

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 15, 1943

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3143 STAFFORD ST.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PUBLIC WORKS SUPV.

16b. Kind of Business/Industry

D.C. PUBLIC WORKS DEPT.

17. Father's Name (First, Middle, Last)

CLARENCE L. JASPER

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH P. ROBINSON

19a. Informant's Name/Relationship (Type, Print)

GARY A. JASPER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3143 STAFFORD ST., BALTIMORE, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CULPEPER NAT. CEMETERY 02/15/11

Date

20c. Location - City or Town, State

CULPEPER, VA

21. Signature of Funeral Service Licensee

Kenneth J. Robinson

22. Name and Address of Facility

W.C. THOMPSON FUNERAL HOME, INC.  
503-7 NORTH MAIN ST., CULPEPER, VA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro Vascular Accident  
Due to (or as a consequence of):b. Hypertension  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4-months

30 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/O Prostate Cancer

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☒ Other (Specify) Son's

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mario Nicholson

29c. License number

D0041747

29d. Date signed (Month, Day, Year)

02/07/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mario Nicholson 6525 Belcrest Rd., Hyattsville, MD 20782

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Kenneth J. Robinson

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

3


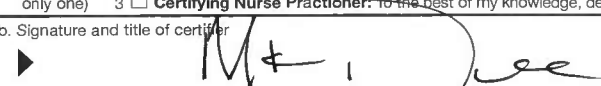

State  
Registrar



1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |
|---|---|---|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Martha Eleanor Jackson</b>   |   |   | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>9:30 A.M.</b>   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Doctors Community Hospital</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-34-2223</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>100</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>04/09/1910</b>   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Seabrook, Md.</b>  |   |   |   |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |   |  |  |  |
|   | 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>P.G.</b>  |   | 10c. City, Town or Location<br><b>Lanham</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>5516 Belva Place</b>   |   |   | 10f. Zip Code<br><b>20706</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |   | 16b. Kind of Business Industry<br><b>Own Home</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Arthur Chittams</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy Henry</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thelma B. Butler/Daughter</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>704 Avis Drive, Largo, Maryland 20774</b> |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Mem. Park</b>  |   | Date<br><b>02/12/11</b>  |  | 20c. Location - City or Town, State<br><b>Landover, Maryland</b>                                   |
|   | 21. Signature of Funeral Service Licensed<br>  |   | 22. Name and Address of Facility<br><b>Henry S. Washington &amp; Sons Co., Inc.<br/>4925 Burroughs Ave., N.E., Washington, D.C. 20019</b>             |   |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac Arrhythmia</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |   |   |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |   | 23d. Date of delivery<br>Month Day Year  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D0023125</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2-7-11</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M.K. Mohan, M.D. 6502 Kenilworth Avenue # 100, Riverdale, Maryland 20737</b>   |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |   | 32. Registrar's Signature<br>  |   |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1- For State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner

1. Decedent's Name (First, Middle, Last)

Daniel J. Klein

2. Date of Death

February 6, 2011

3. Time of Death

1559 hrs

4a. Facility Name (if not institution, give street and number)

204 East K Street

4b. City, Town, or Location of Death

Brunswick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

193-52-6330

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

April 5, 1958

9. Birthplace (State or Foreign)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

204 East K Street

10f. Zip Code

21716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Manager

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Victor Klein

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Baldwin

19a. Informant's Name/Relationship (Type, Print)

Eric Klein / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

504 Primus Court, Frederick, MD 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven

Date

2/11/2011

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

*Jonathan Stauffer*

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike, Frederick, MD 21702

23a. (Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)

Immediate Cause (Final disease or condition resulting in death)

a. Complications of Chronic Alcohol Use

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other: Scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Donna M. Vincenti*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

*Donna M. Vincenti*State  
RegistrarBaltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State of Maryland / Department of Health and Mental Hygiene

e-2011 05896

## Certificate of Death

**1- For State Registrar**

Reg. No. \_\_\_\_\_

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State  
Registrar**

**Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**

2011 05897

**Certificate of Death**

Reg. No.

**Physician/  
Medical Examiner**

**1- For State  
Registrar**

1. Decedent's Name (First, Middle, Last)

Sarah Patricia Kelly

2. Date of Death  
Month Day Year  
February 6, 20113. Time of Death  
1046 hrs4a. Facility Name (if not institution, give street and number)  
PRMC4b. City, Town, or Location of Death  
Salisbury4c. County of Death  
Wicomico

**Funeral  
Director**

5. Social Security Number  
216-48-52276. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
63 Yrs.If Under 24 Hrs.  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
03/20/1947

9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent

10a. State  
MD10b. County  
Wicomico10c. City, Town or Location  
Fruitland10d. Inside City Limits  
1 ☐ Yes 2 ☐ No

10e. Street and Number

111C Linda Dr.

10f. Zip Code

21826

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

medical records supervisor

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

James R. Kelly, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Jones Kelly

19a. Informant's Name/Relationship (Type, Print)

Jim R. Kelly, Jr. (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9943 Beaverdam Creek Rd. Berlin, MD 21811

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

1st State Crematory

Date

02/10/2011

20c. Location - City or Town, State

Millsboro, DE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

The Burbage Funeral Home  
108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☐ UNPENDED☐ AMENDED

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions

contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

OCME

**State  
Registrar**

**Baltimore, MD 21215-0036**

**Division of Vital Records, P.O. Box 68760,**  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05898

1- For State Registrar

Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grayson Edward Kenney Sr.

2. Date of Death

02 08 2011

3. Time of Death

11:15 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Coastal Hospice at the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

220-26-7912

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

8. Date of Birth

June 24, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

29310 Connelly Mill Road

10f. Zip Code

21875

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Retired Police Chief

16b. Kind of Business Industry

Dept. Salisbury City Police

17. Father's Name (First, Middle, Last)

James Kenney

18. Mother's Name (First, Middle, Maiden Surname)

Grace Church

19a. Informant's Name/Relationship (Type, Print)

Lillian Delores Kenney/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29310 Connelly Mill Road - Delmar, Maryland 21875

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Gardens

Date

02/15/2011

20c. Location - City or Town, State

Hebron, Maryland

21. Signature of Funeral Service Licensee

Patricia A. Jolley

22. Name and Address of Facility

Salisbury, Maryland  
Jolley Memorial Chapel - 1213 Jersey Road 21801

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT LIVER CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

☐ Yes ☒ No  
☐ Unknown

23c. If yes, outcome of pregnancy

☐ Live Birth ☐ Fetal death ☐ Ectopic pregnancy  
☐ Pregnant at time of death ☐ Other (Specify)  
☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DCA ☐ Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) HOSPICE

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide ☐ Homicide  
☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

12MP

29c. License number

00058410

29d. Date signed (Month, Day, Year)

02-08-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHUAN WANG PO BOX 1737 SALISBURY MD 21804

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Anna D. Parker

State Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Grayson Kenney  
Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05899

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur C. Kirk

2. Date of Death  
Month Day Year  
February 2, 20113. Time of Death  
5:35 A M

4a. Facility Name (if not institution, give street and number)

Regency Park

4b. City, Town, or Location of Death

Gambrills

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

232-26-3517

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

9. Birthplace (State or Foreign Country)

9/6/1920

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

New Carrollton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5810 Oland Dr

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Officer

16b. Kind of Business Industry

National Security Agency

17. Father's Name (First, Middle, Last)

Edgar K. Kirk

18. Mother's Name (First, Middle, Maiden Surname)

Ethel M. Twigg

19a. Informant's Name/Relationship (Type, Print)

David Kirk (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1708 Tarleton Way Crofton, MD 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat. Cem.

Date

02/23/2011

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Richard Bent

22. Name and Address of Facility

Rendon/Hale Funeral Home

9013 Annapolis Rd. Lanham, MD 20706

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

b. Cardiovascular disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years.

3 years.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Farhad Jamali MD

29c. License number

D0058213

29d. Date signed (Month, Day, Year)

2/3/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARHAD JAMALI MD 12150 Annapolis Rd Green Dale MD 20769

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Kenna D. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05900

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James

Wilson

Leitch

2. Date of Death

Month

Day

Year

3. Time of Death

0200 M

4a. Facility Name (if not institution, give street and number)

Western MD Regional Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

214-54-9002

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

08/18/1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

Bedford

10c. City, Town or Location

Clearville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

122 Valentine Acre Road

10f. Zip Code

15535

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

1971-

1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business Industry

Trucking

17. Father's Name (First, Middle, Last)

Preston

Dudley

Leitch, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Annie

Dell

Kersey

19a. Informant's Name/Relationship (Type, Print)

Catherine M. Leitch / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

122 Valentine Acre Road, Clearville, PA 15535

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cumberland Crematory

Date

01/28/2011

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

Adams Family Funeral Home, P.A.

22. Name and Address of Facility

404 Decatur Street, Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiorespiratory Arrest

Due to (or as a consequence of):

b. Severe Cardiomyopathy and End Stage

Due to (or as a consequence of):

c. Severe Pulmonary Hypertension

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease  
Type 2 DM, Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Physician/Nephrologist

29c. License number

D0065083

29d. Date signed (Month, Day, Year)

01/27/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph T. Karyl, MD, 915 Selton Drive, Cumberland, MD, 21502

31. Date filed (Month, Day, Year)

JAN 28 2011

32. Registrar's Signature

Dana S. Parker

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05901

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|                                     |   |  |   |  |   |  |  |  |
|-------------------------------------|---|--|---|--|---|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Keith Scott Lemon</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>3:26 P M</b>  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>12605 Arcus Court</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Upper Marlboro</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>228 44 0808</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 20, 1940</b>   |  |
|                                     | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Upper Marlboro</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|                                     | 10e. Street and Number<br><b>12605 Arcus Court</b>  |  |   |  | 10f. Zip Code<br><b>20772</b>   |  | 10g. Citizen of What Country?<br><b>United State</b>   |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1959-1963</b><br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Imagery Analyst</b>   |  | 16b. Kind of Business Industry<br><b>Central Intelligence Agency</b>  |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Keith Miller Lemon</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hazel Victoria Scott</b>  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean L. Lemon (wife)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12605 Arcus Court, Upper Marlboro, MD 20772</b>   |  |  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee Crematory</b>  |  | Date<br><b>Feb 12, 2011</b>   |  | 20c. Location - City or Town, State<br><b>Clinton, MD</b>  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility <b>Lee Fuenral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735</b>   |  |   |  |  |  |
|                                     | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Ischemic Heart Disease</b><br>Due to (or as a consequence of):<br><b>Hypertensive Heart Disease</b><br>Due to (or as a consequence of):<br><b>Chronic Obstructive Lung Disease</b><br>Due to (or as a consequence of):<br><b></b>  |  |   |  |   |  |  |  |
|                                     | Approximate Interval Between Onset and Death<br><b>Expired on 02/08/11 at 3:26 pm</b>   |  |   |  |   |  |  |  |
| Physician/<br>Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |   |  | 23d. Date of delivery<br>Month Day Year  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hyperlipidemia</b><br><b>Hypertension</b>  |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
|                                     | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D35295</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>02/11/11</b>   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SATISH SUMANI, M.D. 10 St. Patricks Drive, Suite 208, Waldorf, MD 20603</b>  |  |   |  |   |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

7851077

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State of Maryland / Department of Health and Mental Hygiene

2011 05902

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Eugene Michael Lucas, Sr.   |  |   |  | 2. Date of Death<br>Month 02 Day 09 Year 2011  |  | 3. Time of Death<br>66:10 A M  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br>Coastal Hospice at the lake   |  |   |  | 4b. City, Town, or Location of Death<br>Salisbury  |  | 4c. County of Death<br>Wicomico  |  |
| Funeral<br>Director  | 5. Social Security Number<br>181-12-4006  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>11/20/1921  |  |
|  | 9. Birthplace (State or Foreign Country)<br>PA  |  | 10a. State<br>MD  |  | 10b. County<br>Worcester   |  | 10c. City, Town or Location<br>Ocean City  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>14003 Loop Rd.  |  | 10f. Zip Code<br>21811   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Seconday (0-12) 4   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Administrator                            |  | 16b. Kind of Business Industry<br>Government   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>unknown  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Kanisak   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print) daughter<br>Erika L. Lucas/ in-law   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14003 Loop Rd., Ocean City, MD 21842  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>First State Crem.   |  | 20c. Location - City or Town, State<br>Millsboro, DE   |  | 20d. Date<br>2/10/11   |  |
|  | 21. Signature of Funeral Service Licensee<br>BMB Maxfield   |  |   |  | 22. Name and Address of Facility<br>Burbage Funeral Home<br>108 William St., Berlin, MD 21811  |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. LARYNGEAL CARCINOMA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):   |  |   |  |  |  |  |  |
|  | 23b. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   |  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]   |   |  |   | 29c. License number<br>D0058460  |  | 29d. Date signed (Month, Day, Year)<br>02-09-11                                      |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Eugene Michael Lucas, Sr. 1733 SALISBURY MD. 21802   |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 10 2011   |   |  |   | 32. Registrar's Signature<br>[Signature]   |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05903

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lola Lawrence

2. Date of Death  
Month Day Year  
February 4, 20113. Time of Death  
9:45 a MFuneral  
Director

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

336-12-2832

6. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
88 Yrs.If Under 1 Year  
Months Days Hours Min.If Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Dec. 10, 19229. Birthplace (State or Foreign  
Country)  
Illinois

Usual Residence of Decedent

10a. State  
MD10b. County  
Anne Arundel10c. City, Town or Location  
Annapolis10d. Inside City Limits  
1 ☐ Yes 2 ☒ No10e. Street and Number  
1188 St. George Drive10f. Zip Code  
2140910g. Citizen of What Country?  
USA11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)  
1216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Administration16b. Kind of Business Industry  
Accounting

17. Father's Name (First, Middle, Last)

William Bocknor

18. Mother's Name (First, Middle, Maiden Surname) (UNK)  
Mary

19a. Informant's Name/Relationship (Type, Print)

Raymond A. Bocknor/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2213 Southeast 14th Street Cape Coral, FL 33990

20a. Method of Disposition  
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Hillcrest Memorial

Date unk

20c. Location - City or Town, State  
Annapolis, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Ritchie Hwy. Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. COPD  
Due to (or as a consequence of):

8 days

c. Tobacco Abuse  
Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury  
M28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H0070782

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karin Goulet Health Services Pavilion 2000 Medical Parkway #607 Annapolis, MD

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

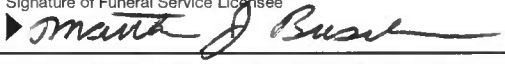


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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05904

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Carrie Mae Lorenzetti</b>  |  | 2. Date of Death<br>Month: <b>February</b> Day: <b>6</b> Year: <b>2011</b>  |  | 3. Time of Death<br><b>6:32 P</b> M   |   |
| 4a. Facility Name (if not institution, give street and number)<br><b>Doctors Community Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  | 4c. County of Death<br><b>Prince Georges</b>  |   |
| 5. Social Security Number<br><b>499-22-7569</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |   |
| 8. Date of Birth (Month, Day, Year)<br><b>Aug. 26, 1924</b>   |  | 9. Birthplace (State or Foreign)<br><b>Arkansas</b>   |  |   |   |
| Usual Residence of Decedent   |  |   |  |   |   |
| 10a. State<br><b>VA</b>   |  | 10b. County<br><b>Arlington</b>   |  | 10c. City, Town or Location<br><b>Arlington</b>   |   |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>808 S. 21st Street</b>   |  | 10f. Zip Code<br><b>22202</b>   |   |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b><br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Person</b>  |  | 16b. Kind of Business Industry<br><b>Retail</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>William Cissell</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Belle Landis</b>  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles L. Lorenzetti/Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11400 Prospect Ct. Glendale, MD 20769</b>   |  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>National Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Falls Church, VA</b>  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Murphy FH 4510 Wilson Blvd. Arl., VA 22203</b>   |  |   |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Heart Failure (Acute)</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):                 |  |   |  |   | Approximate Interval Between Onset and Death  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown  |  |   |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) |
| 23d. Date of delivery<br>Month Day Year   |  |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |   |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D70967</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/6/2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Amit Wadhwa 8118 Good Luck Road Lanham, Maryland 20706</b>   |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |  | 32. Registrar's Signature<br>  |  |   |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Lorenzetti, Carrie

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05905

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |   |   |  |
|--|--|---|--|--|--|--|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EARL CALVIN LENHART SR</b>  |  |   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>15</b> Year <b>2011</b>   |  |  |   | 3. Time of Death<br><b>3:20 P M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>FREDERICK MEMORIAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>   |  |  |   | 4c. County of Death<br><b>FREDERICK</b>   |  |
| 5. Social Security Number<br><b>215-26-2190</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>Aug. 24, 1929</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
| Usual Residence of Decedent  |  |   |  |  |  |  |   |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>4731 Araby Church Road</b>  |  |   |  | 10f. Zip Code<br><b>21704</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>1951-1953</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bricklayer/Mason</b>   |  |  | 16b. Kind of Business Industry<br><b>Construction</b>                   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Louis C. Lenhart</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naoma Rice</b>   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Betty A. Lenhart, wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4731 Araby Church Road, Frederick, MD 21704</b>  |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery</b>   |  | Date<br><b>Feb. 18, 2011</b>   |   | 20c. Location - City or Town, State<br><b>Frederick, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b> <b>M00255</b>  |  |   |  | 22. Name and Address of Facility<br><b>Keeney and Basford PA Funeral Home</b><br><b>106 East Church St., Frederick, MD 21701</b>   |  |  |   |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> Due to (or as a consequence of):   |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  |   |  |  |  |  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b><br><b>High blood pressure</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  | 29c. License number<br><b>D-51643</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/15/11</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Helen N. Shah, MD 65 c. Thomas Johnson Dr Frederick MD</b>  |  |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05906

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mabel Lewis</b>  |   | 2. Date of Death<br>Month <b>02</b> Day <b>18</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>7:55 P M</b>   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Goodwill Retirement Community</b>  |   | 4b. City, Town, or Location of Death<br><b>Grantsville</b>   |  | 4c. County of Death<br><b>Garrett</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-07-4665</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>01/29/1913</b>   |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |   | 10. Usual Residence of Decedent  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Allegany</b>  | 10c. City, Town or Location<br><b>Frostburg</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>100 Honeysuckle Lane, Apt. 303</b>   |   | 10f. Zip Code<br><b>21532</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business Industry<br><b>Home</b>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles B. Evick</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Icie Phillips</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Allan Lewis / Son</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15114 Trail Ridge Road, SW, Cumberland, MD 21502</b> |  |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>02/21/2011 Cumberland, MD</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>John J. Hafer, Jr.</b>  |   | 22. Name and Address of Facility<br><b>Hafer Funeral Service, P.A. 1302 National Highway, LaVale, MD 21502</b>   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebral vascular accident (stroke)</b><br>Due to (or as a consequence of):<br>b. <b>generalized atherosclerosis</b><br>Due to (or as a consequence of):<br>c. <b>hypertension</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>years</b><br><b>years</b> |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>prior hemorrhagic CVA,</b>   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |   |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Margaret A. Kaiser MD</b>   |   | 29c. License number<br><b>D26650</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-19-2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>margaret a. kaiser md; 13079 garrett highway; Oakland, Md 21550</b>  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>   |   | 32. Registrar's Signature<br><b>Denise S. [Signature]</b>   |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|                                     |  |  |   |  |  |  |  |  |
|-------------------------------------|--|--|---|--|--|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Steven Richard Lipinski</b>   |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>01:16 PM</b>  |  |
|                                     | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Health Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>214-38-6771</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 10, 1942</b>  |  |
|                                     | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, MD</b>   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hancock</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|                                     | 10e. Street and Number<br><b>14513 Heavenly Acres Ridge</b>  |  |   |  | 10f. Zip Code<br><b>21750</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  | 16b. Kind of Business Industry<br><b>Trucking</b>  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Howard Francis Lipinski</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Eva Grob</b>  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandra J. Lipinski- Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14513 Heavenly Acres Ridge, Hancock, MD 21750</b>  |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |  | 20c. Date<br><b>2-17-2011</b>  |  | 20d. Location - City or Town, State<br><b>Hagerstown, MD</b>   |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Doglan C. Searles</b> M00522   |  |   |  | 22. Name and Address of Facility<br><b>Helsley-Johnson FH &amp; Cremation Center</b><br><b>95 Union St., Berkeley Springs, WV 25411</b>  |  |  |  |
|                                     | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute Respiratory Failure</b><br>Due to (or as a consequence of):<br>b. <b>Acute Pneumonia Pneumonia</b><br>Due to (or as a consequence of):<br>c. <b>Radiation Pneumonitis</b><br>Due to (or as a consequence of):<br>d. <b>Lung Cancer</b>   |  |   |  |  |  |  |  |
|                                     | Approximate Interval Between Onset and Death<br><b>3 weeks</b><br><b>3 weeks</b><br><b>4 weeks</b><br><b>8 months</b>  |  |   |  |  |  |  |  |
| Physician/<br>Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  | 23d. Date of delivery<br>Month Day Year  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumocystis pneumonia</b><br><b>COPD</b>   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|                                     | 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
|                                     | 29b. Signature and title of certifier<br><b>Michael McCormack MD</b>   |  |   |  | 29c. License number<br><b>041667</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2-14-11</b>  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael McCormack 11110 Medical Campus Hagerstown MD</b>  |  |   |  |  |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  |   |  | 32. Registrar's Signature<br><b>Anna S. Gail</b>   |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene

2011 05908

Certificate of Death

Reg. No.

1- For State Registrar

Physician/ Medical Examiner

1. Decedent's Name (First, Middle, Last) **KATHERINE KRISTIN MURRAY** 2. Date of Death Month **February** Day **9** Year **2011** 3. Time of Death **2306 hrs**

Funeral Director

4a. Facility Name (if not institution, give street and number) **Oliver Shop Road at Grosstown Road** 4b. City, Town, or Location of Death **Hughesville** 4c. County of Death **Charles**

5. Social Security Number **215-43-6729** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **16** Yrs. 8. Date of Birth (MM/DD/YYYY) **3-8-1994** 9. Birthplace (State or Foreign Country) **MD.**

Usual Residence of Decedent 10a. State **MD.** 10b. County **CHARLES** 10c. City, Town or Location **LA PLATA** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **11871 KNOLLCREST LANE** 10f. Zip Code **20646** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No specify: 14. Race - American Indian, Black, White, etc. Specify **WHITE**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **10th** College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **STUDENT** 16b. Kind of Business/Industry **LA PLATA HIGH SCHOOL**

17. Father's Name (First, Middle, Last) **STEPHEN M. MURRAY** 18. Mother's Name (First, Middle, Maiden Surname) **CHRISTINE M. LYONS**

19a. Informant's Name/Relationship (Type, Print) **STEPHEN MURRAY-FATHER** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **11871 KNOLLCREST LN. LA PLATA, MD. 20646**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) **ST. MARY'S CEMETERY** Date **2-16-11** 20c. Location - City or Town, State **NEWPORT, MD.**

21. Signature of Funeral Service Licensee **M00479** 22. Name and Address of Facility **RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **a. Head and Neck Injuries** Due to (or as a consequence of): **2 per me g912 2-25-11 vt** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **d.** Due to (or as a consequence of): **AMENDED** ☐ UNPENDED ☒ **Approximate Interval Between Onset and Death**

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐ Yes ☐ No ☒ Unknown 23c. If yes, outcome of pregnancy ☐ Live birth ☐ Fetal death ☐ Ectopic pregnancy ☐ Pregnant at time of death ☐ Other (Specify) ☐ Unknown 23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown 24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☒ Yes ☐ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other: Scene

27. Manner of Death ☐ Natural ☒ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) **FOUND: Feb 9, 2011** 28b. Time of Injury **FOUND: 2304 hrs** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred **Driver auto collision**

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Ana Rubio MD.** 29c. License number **O.C.M.E.** 29d. Date signed (Month, Day, Year) **February 10, 2011**

30. Name and address of person who completed cause of death (Item 23a) **Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223**

31. Date filed (Month, Day, Year) **FEB 23 2011** 32. Registrar's Signature **[Signature]**

State Registrar

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760, #2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

To Be Completed by Funeral Director To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05909

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |   |
|---|---|---|---|--|--|--|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>John Charles Means                                    |   |   | 2. Date of Death<br>Month February Day 5, Year 2011  |  | 3. Time of Death<br>9:50 A M   |   |
|   | 4a. Facility Name (if not institution, give street and number)<br>Devlin Manor Health Care Center |   |   | 4b. City, Town, or Location of Death<br>Cumberland   |  | 4c. County of Death<br>Allegany  |   |
| Funeral<br>Director   | 5. Social Security Number<br>185-12-9360  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>11/06/1921               |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |   |   |  |  |  |   |
| Usual Residence of Decedent   |   |   |   |  |  |  |   |
| 10a. State<br>MD  |   | 10b. County<br>Allegany   |   | 10c. City, Town or Location<br>Cumberland  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br>11710 Bedford Road, NE  |   |   | 10f. Zip Code<br>21502  |  | 10g. Citizen of What Country?<br>USA   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Owner                            |  | 16b. Kind of Business Industry<br>Retail   |  |   |
| 17. Father's Name (First, Middle, Last)<br>John Americus Means  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Elizabeth Bruckman   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert A. Means / Son   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11714 Bedford Road, NE, Cumberland, MD 21502 |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sunset Memorial Park  |   | Date<br>02/08/2011   |  | 20c. Location - City or Town, State<br>Cumberland, MD  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502                               |  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Myocardial infarction</i>  |   |   |   |  |  |  | Approximate Interval Between Onset and Death<br><i>2 months</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter the underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.   |   |   |   |  |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Portulacaria - dead to chemotherapy</i>  |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28d. Describe how injury occurred  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |   |
| 29a. Certifier<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>(Check only one) 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   |   | 29c. License number<br>D0017505   |  | 29d. Date signed (Month, Day, Year)<br>Feb. 7, 2011  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ATBoline MD 922 Nat'l Hwy L2U212, MD 21502  |   |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>FEB 07 2011  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05910

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Joseph Warren McGowan Sr.

2. Date of Death

2 1 11

3. Time of Death

4:35 AM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital Oakland, MD

4b. City, Town, or Location of Death

Oakland, MD

4c. County of Death

Garrett

5. Social Security Number

218 40 3253

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-9-1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Garrett10c. City, Town or Location  
Oakland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number 4 South 4th Street

10f. Zip Code

21550-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Saloon

17. Father's Name (First, Middle, Last)

Joseph P. McGowan

18. Mother's Name (First, Middle, Maiden Surname)

Mildred E. Wam

19a. Informant's Name/Relationship (Type, Print)

Joseph McGowan, Jr Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt 3 Box 404C Ridgeley West Virginia 26753-

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cumberland Crematory

Date

February 05, 2011

20c. Location - City or Town, State

Cumberland Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. malignant melanoma w/4  
metastasis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

H26154

29d. Date signed (Month, Day, Year)

2/01/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Daniel Miller 69 Wolf Acres Dr Oakland MD

31. Date filed (Month, Day, Year)

FEB 02 2011

32. Registrar's Signature

[Signature]

21550

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05911

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Loretta Belle Brotemarkle Smith McAlpine

2. Date of Death  
Month Day Year

1 29 2011

3. Time of Death

8:14A<sup>M</sup>

4a. Facility Name (if not institution, give street and number)

Western MD Regional Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

217-10-5299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

01/04/1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11708 Bayberry Avenue

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business Industry

Retail Sales

17. Father's Name (First, Middle, Last)

F. Rolland Brotemarkle

18. Mother's Name (First, Middle, Maiden Surname)

Belva Growden

19a. Informant's Name/Relationship (Type, Print)

J. Robert Smith / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11708 Bayberry Avenue, Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

02/02/2011

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

► *[Signature]*

22. Name and Address of Facility

Upchurch Funeral Home, P.A.  
202 Greene Street, Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):  
b. Cholangitis  
Due to (or as a consequence of):  
c. Colon cancer.  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *[Signature]*

29c. License number

D23167

29d. Date signed (Month, Day, Year)

11/29/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Juan Arrisueno, M.D. - 903 Baton Drive, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

FEB 03 2011

32. Registrar's Signature

► *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05912

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |   |   |
|---|--|--|---|---|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Hugh Felix Malamphy  |  | 2. Date of Death<br>Month Day Year<br>January 30, 2011  |   | 3. Time of Death<br>7:15 A M  |
|   | 4a. Facility Name (if not institution, give street and number)<br>619 Hilltop Drive  |  | 4b. City, Town, or Location of Death<br>Cumberland  |   | 4c. County of Death<br>Allegany   |
| Funeral<br>Director   | 5. Social Security Number<br>220-32-2660   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>75 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>02/05/1935       |   |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |   |   |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |  | 10b. County<br>Allegany   |   | 10c. City, Town or Location<br>Cumberland   |
|   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |   |
|   | 10e. Street and Number<br>619 Hilltop Drive  |  | 10f. Zip Code<br>21502  |   | 10g. Citizen of What Country?<br>USA  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Dean of Continuing Education   |   | 16b. Kind of Business Industry<br>College   |
|   | 17. Father's Name (First, Middle, Last)<br>Thomas J. Malamphy  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche Rowley   |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary E. Malamphy / Wife  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>619 Hilltop Drive, Cumberland, Maryland 21502  |   |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cumberland Crematory  |   | 20c. Location - City or Town, State<br>Cumberland, MD   |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br>Adams Family Funeral Home, P.A.<br>404 Decatur Street, Cumberland, MD 21502   |   |   |
| Physician/<br>Medical<br>Examiner   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Hepatocellular Carcinoma</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):  |  |   |   | Approximate Interval Between Onset and Death<br>3 yrs   |
|   | 23b. IF FEMALE:<br>Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify) |
|   | 23d. Date of delivery<br>Month Day Year  |  |   |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M  |
|   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br>D33280  |   | 29d. Date signed (Month, Day, Year)<br>January 31, 2011 |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 21502 |  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br>JAN 31 2011  |  | 32. Registrar's Signature<br><i>[Signature]</i>                                |   |   |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760

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Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05913

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |  |
|---|---|---|---|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Josephine Mahoney</b>  |   |   |   | 2. Date of Death<br>Month <b>Feb.</b> Day <b>8,</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>6:10 p.m.</b>   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>6505 Rosemont Street</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Upper Marlboro</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213 44 5823</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>March 19, 1931</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>                                     |  |
|   | Usual Residence of Decedent   |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>Upper Marlboro</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>6505 Rosemont Street</b>   |   |   |   | 10f. Zip Code<br><b>20772</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  | 16b. Kind of Business Industry<br><b>Nursery School</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Josef Kern</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lydia Ernst</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patrizia Szymkowicz (daughter)</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13332 Scibilia Court, Fairfax, Va 22033</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee Crematory</b>  |   | Date<br><b>Feb 11, 2011</b>  |  | 20c. Location - City or Town, State<br><b>Clinton, MD</b>                                      |  |
|   | 21. Signature of Funeral Service Licensee<br>m01533   |   |   |   | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary artery disease</b><br>Due to (or as a consequence of):<br>a. <b>Pericarditis</b><br>Due to (or as a consequence of):<br>b. <b>herpes erythematosis</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |   |   |   |  |  |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   |  |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>           |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 28d. Describe how injury occurred   |   |   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D19633</b>      |  | 29d. Date signed (Month, Day, Year)<br><b>02/09/2011</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John C. Patterson, MD 7501 Surratts Rd #201 Clinton, MD</b>  |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |   | 32. Registrar's Signature<br>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Medical Certificate: To Be Completed by Physician/Medical Examiner

2310

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05914

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia S. Mizak

2. Date of Death

Month Feb. 8, Day 2011 Year

3. Time of Death

3:38 PM

4a. Facility Name (if not institution, give street and number)

Civista Hospital

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

577 34 1532

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 29, 1928

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Capitol Heights,

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9411 Chestnut Park Street

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk/Typist

16b. Kind of Business Industry

Government

17. Father's Name (First, Middle, Last)

William E. Schottroff

18. Mother's Name (First, Middle, Maiden Surname)

Ethel V.

19a. Informant's Name/Relationship (Type, Print)

Richard Mizak

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9411 Chestnut Park Street, Capitol Heights, MD 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

Feb 15, 2011

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

[Signature] MO1533

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION  
Due to (or as a consequence of):  
b. CORONARY ARTERY DISEASE  
Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) OFFICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D12906

29d. Date signed (Month, Day, Year)

2/9/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Wisotsky, MD 700 Old Line Center, Suite 207, Waldorf, MD 20602

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

[Signature]

State  
RegistrarBaltimore, Maryland 21215-0036  
Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerDivision of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

286

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05915

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |
|--|--|---|---|--|--|---|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Brian Hughes Marshall</b>   |   | 2. Date of Death<br>Month <b>February</b> Day <b>14</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>11:40 a M</b>   |   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Hospice House of St. Mary's</b>   |   | 4b. City, Town, or Location of Death<br><b>Callaway</b>   |  | 4c. County of Death<br><b>St. Mary's</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>137-30-1667</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>08/31/1940</b>   |  |   |
|  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |   |   |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>St. Mary's</b>  | 10c. City, Town or Location<br><b>Hollywood</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>24664 Paradise Lane</b>   |   | 10f. Zip Code<br><b>20636</b>   |  | 10g. Citizen of What Country?<br><b>U S A</b>  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>6</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Technical Director</b>              |  | 16b. Kind of Business Industry<br><b>Government Contractor</b>                                 |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Leo J. Marshall</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Hughes</b>  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>David Marshall/Son</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11937 Molly Pitcher Cr., Manassas, VA 20109</b> |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John Francis Reg.</b>  |  | 20c. Location - City or Town, State<br><b>Hollywood, MD</b>                                    |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Shawn Aylesworth M01521</b>  |   | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>                            |  |  |   |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>LUNG CANCER</b><br>Approximate Interval Between Onset and Death<br><b>YEARS</b> |   |   |  |  |   |
|  | 23b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.   |   |   |  |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>9 Unknown  |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live Birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) |   | 23d. Date of delivery<br>Month Day Year  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice House</b>  |   |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   | 28a. Date of injury (Month, Day, Year)   | 28b. Time of injury<br>M  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>   |  | 29c. License number<br><b>D56096</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2-14-11</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAJINDER S. GILL MD SMAR ASSOCIATES LEONARDTOWN MD</b>  |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 16 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State  
Registrar

DHMH 17 Rev 7/2009

ORIGINAL

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |   |  |  |
|---|--|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charlotte Frances Messenger</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> Year <b>2011</b>  |  |  |   | 3. Time of Death<br><b>7:00 A M</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Citizens Care &amp; Rehab Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  |  |   | 4c. County of Death<br><b>Frederick</b>  |  |
| 5. Social Security Number<br><b>220-34-2326</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 11, 1927</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>5613 Boone Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21704</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George V. Harper</b>  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Daisy L. Baker</b> |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Bowers / Friend</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8039 Chestnut Grove Rd., Frederick, MD 21701</b>   |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>  |  | Date<br><b>Feb. 8, 2011</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Resthaven Funeral Services, Skkot Cody P.A.<br/>9501 Catoctin Mountain Hwy. Frederick, MD 21701</b>   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Primary Carcinoma of Liver</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>1 Year</b>                                      |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  |  |  |  |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D13971</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>2/7/11</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert L. Kaufmann, M.D. 300 West 9th Street, Frederick, MD 21701</b>  |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 08 2011</b>   |  |   |  | 32. Registrar's Signature<br>  |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per med cert 6913 3/8/11 dk

State of Maryland / Department of Health and Mental Hygiene

2011 05917

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |                          |   |   |   |  |  |   |  |  |
|---|---|--------------------------|---|---|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Esther L. McCann</b>   |                          |   |   |   |  | 2. Date of Death<br>Month <b>02</b> Day <b>07</b> Year <b>2011</b> |   | 3. Time of Death<br><b>1800 P M</b>  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Peninsula Regional Medical Center</b>  |                          |   |   |   |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>           |   | 4c. County of Death<br><b>Wicomico</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-32-1346</b>   |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>09/26/1936</b>           |   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                                  |  |
|   | Usual Residence of Decedent   |                          |   |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |                          | 10b. County<br><b>Wicomico</b>  |   | 10c. City, Town or Location<br><b>Salisbury</b>   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>4028 Meadowbridge Rd.</b>  |                          |   |   | 10f. Zip Code<br><b>21804</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                        |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>  |                          |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>caregiver</b>   |  |  | 16b. Kind of Business Industry<br><b>health care</b>                    |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Walter A. McCann</b>  |                          |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lelia Johnson</b>  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan Ness/daughter</b>  |                          |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>338 Holiday St., Fruitland, MD 21826</b> |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b> |   | Date<br><b>2/12/2011</b>   |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>             |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |                          |   |   |   | 22. Name and Address of Facility<br><b>Holloway Funeral Home Professional Association<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>         |  |   |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Atherosclerotic Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |                          |   |   |   |  |  |   |  |  |
|   | 23b. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown   |                          |   |   |   |  |  |   |  |  |
| 23d. Date of delivery<br>Month Day Year   |   |                          |   |   |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                          |   |   |   |  |  |   |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |                          |   |   |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   |   |   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                          |   |   |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   |   |   |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |                          |   |   |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |                          |   |   |   |  |  |   |  |  |
| 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                    |   | 28d. Describe how injury occurred  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                          |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                          |   |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |                          |   |   | 29c. License number<br><b>054127</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/7/11</b>               |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alon Davis MD 100 Power St. Salisbury, MD 21804</b>  |   |                          |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |   |                          |   |   |   |  |  |   |  |  |
| 32. Registrar's Signature<br>   |   |                          |   |   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

10 IMP

State  
Registrar



Reg. No.

ORIGINAL

1- For State Registrar

Certificate of Death

Reg. No.

2011 05919

Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

|   |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>John Eric Machlinski</b>   |  |  |  | 2. Date of Death<br><b>February 5, 2011</b>  |  |   |  | 3. Time of Death<br><b>1:50 P M</b>   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>1147 Gypsum Drive</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Hampstead</b>   |  |   |  | 4c. County of Death<br><b>Carroll County</b>  |  |  |  |
| 5. Social Security Number<br><b>216-70-3978</b>   |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  |  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 13, 1960</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  |  |  |  |  |   |  |   |  |  |  |
| 10b. County<br><b>Carroll County</b>  |  |  |  | 10c. City, Town or Location<br><b>Hampstead</b>  |  |   |  | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  |  |  |
| 10e. Street and Number<br><b>1147 Gypsum Drive</b>  |  |  |  | 10f. Zip Code<br><b>21074</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b><br>If Yes, Give Year or Dates. <b>1989</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |  |   |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: white</b>                                   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>delivery driver</b>  |  |   |  | 16b. Kind of Business Industry<br><b>package delivery</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Jacob Machlinski</b>   |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shirley Haines</b>  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rachel L. Machlinski/daughter</b>  |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5834 Blue Hill Road Glenville, PA 17329</b> |  |   |  |  |  |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b> |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>   |  |   |  | 20c. Location - City or Town, State<br><b>Hampstead, Maryland</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Alan C. Luvins</b>  |  |  |  | 22. Name and Address of Facility<br><b>Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074</b>  |  |   |  |   |  |  |  |

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|   |  |  |  |   |  |                                 |  |   |  |                                   |  |   |  |
|---|--|--|--|---|--|---------------------------------|--|---|--|-----------------------------------|--|---|--|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASYSTOLE</b>  |  |  |  |   |  |                                 |  |   |  |                                   |  | Approximate Interval Between Onset and Death<br><b>ONE minute</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CHRONIC ARTERY DISEASE - SEVERE</b>  |  |  |  |   |  |                                 |  |   |  |                                   |  | <b>10 (Ten years)</b>   |  |
| <b>HYPERTENSION</b>   |  |  |  |   |  |                                 |  |   |  |                                   |  | <b>Ten years</b>  |  |
| <b>MYOCARDIAL INFARCTION</b>  |  |  |  |   |  |                                 |  |   |  |                                   |  | <b>Ten years</b>  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</b>   |  |  |  | 23c. If yes, outcome of pregnancy<br><b>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)</b>   |  |                                 |  | 23d. Date of delivery<br>Month Day Year   |  |                                   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiac Catheterization - 12/1/10 - Severe Stenosis LAD</b><br><b>Severe Astenosis Right Coronary Artery Stenosis</b>  |  |  |  |   |  |                                 |  |   |  |                                   |  | 23e. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |  |
| 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |                                 |  |   |  |                                   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |                                 |  |   |  |                                   |  |   |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>  |  |  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b> |  | 28c. Injury at work?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  | 28d. Describe how injury occurred |  |   |  |
|   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |                                   |  |   |  |
| 29a. Certifier (Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |   |  |                                 |  |   |  |                                   |  |   |  |
| 29b. Signature and title of certifier<br><b>Sharon Y. Alongi</b>  |  |  |  | 29c. License number<br><b>DOO41725</b>  |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>9/30/2012</b>                                     |  |                                   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sharon Y. Alongi 217 Washington Hgts., Westminster, MD 21157</b>   |  |  |  |   |  |                                 |  |   |  |                                   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |  |  |  | 32. Registrar's Signature<br><b>Sharon B. Sparks</b>  |  |                                 |  |   |  |                                   |  |   |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05920

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGIE L

MAUK

2. Date of Death

Month

Day

Year

02

08

2011

3. Time of Death

1713 M

4a. Facility Name (if not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

214-16-6805

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth

3/14/1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Galesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4844 Church Lane

10f. Zip Code

20765

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business Industry

Food Distribution Program

17. Father's Name (First, Middle, Last)

Ernest Hamilton Smith

18. Mother's Name (First, Middle, Maiden Surname)

Eva Kirchner

19a. Informant's Name/Relationship (Type, Print)

Frankie Lee Parkinson/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4842 Church Lane, Galesville, MD 20765

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodfield Cemetery

Date

2/12/11

20c. Location - City or Town, State

Galesville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute congestive HEART FAILURE

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Michael J. Pentam

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

February 09 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILHA S. LA PENTA 445 DEFENSE HWY ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05921

Physician/  
Medical Examiner1- For State  
Registrar

1. Decedent's Name (First, Middle, Last)

William Lee McDaniels

2. Date of Death

Month Day Year  
February 11, 2011

3. Time of Death

2336 hrs

4a. Facility Name (if not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-40-8926

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24Hrs.

Hours

Min.

8. Date of Birth (MM/DD/YYYY)

1930  
August 25,

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

Washington

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

43 Sheridan Street, N. E.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1951-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

Building Services Supervisor

16b. Kind of Business/Industry

District of Columbia

Public Schools

17. Father's Name (First, Middle, Last)

Samuel McDaniels

18. Mother's Name (First, Middle, Maiden Surname)

Cora Robinson

19a. Informant's Name/Relationship (Type, Print)

Denise Arletha Smith (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3106 Elkridge Court; Beltsville, Maryland 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other Specify:

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cemetery

Date

Feb. 22, 2011

20c. Location - City or Town, State

Quantico, Virginia

21. Signature of Funeral Director

22. Name and Address of Facility

R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 20011

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia Complicating Hypertensive Atherosclerotic Cardiovascular Disease

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED 23a, pt. II, 27 per me g915 5-4-11 vt

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Spinal Stenosis

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pamela E. Southall, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 15, 2011

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 17 2011

32. Registrar's Signature

Dennis B. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05922

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellastine Magaline McNeill

2. Date of Death

January 31, 2011

3. Time of Death

0714 M

4a. Facility Name (If not institution, give street and number)

10404 Fair Lake Terrace

4b. City, Town, or Location of Death

Lake Arbor

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

138-32-1290

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/25/1938

9. Birthplace (State or Foreign Country)

Lanham, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Lake Arbor

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10404 Fair Lake Terrace

10f. Zip Code

20721

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Jerome J. Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Martha Chittams

19a. Informant's Name/Relationship (Type, Print)

Karen Williams/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3805 Elkhorn Circle, Bowie, Maryland 20716

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc. 02/08/11

Date

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Gary A. Cratt

22. Name and Address of Facility

Henry S. Washington & Sons Co., Inc.  
4925 Burroughs Ave., N.E., Washington, D.C. 20019

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Salvador S. Vester

29c. License number

H0055727

29d. Date signed (Month, Day, Year)

February 8, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Vester 3001 Hospital Drive, Chevy Chase, Maryland

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Denise A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05923

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Lusby Metcalfe

2. Date of Death

January 29, 2011

3. Time of Death

3:40 A M

4a. Facility Name (If not institution, give street and number)

Sunrise at Fox Hill

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

576-22-6619

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 24, 1917

9. Birthplace (State or Foreign Country)

Washington

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8300 Burdette Road C-575

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

-4-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Dennis Lusby

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Warrell

19a. Informant's Name/Relationship (Type, Print)

Hal G. Metcalfe - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4700 Autumn Glory Way Chantilly, VA 20151

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National

Date

March 3, 2011

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Robert E. Evans

22. Name and Address of Facility

Jefferson Funeral Chapel  
5755 Castlewellan Drive Alexandria, VA 22315

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. congestive heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. aortic stenosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension  
diabetes mellitus  
atherosclerotic cardiovascular disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted Living

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Roy Fried MD

29c. License number

D34590

29d. Date signed (Month, Day, Year)

2-11-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy Fried MD 7758 Wisconsin Ave, # 211 Bethesda, MD 20814

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Dennis A. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05924

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Mae May

2. Date of Death

Month

Day

Year

3. Time of Death

1010 M

4a. Facility Name (If not institution, give street and number)

WMHS-RMC

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

217-28-0547

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Mar 20, 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

730 Furnace Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Shroyer

19a. Informant's Name/Relationship (Type, Print)

Babara Jean Leasure cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Deal Avenue LaVale MD 21502

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Scarpelli Funeral Home, PA

Date

2/17/2011

20c. Location - City or Town, State

Cresaptown MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA  
108 Virginia Avenue, Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Few days

Few days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Huma Shakil

29c. License number

D46346

29d. Date signed (Month, Day, Year)

2/14/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUMA SHAKIL M.D. 1025 KENT AVENUE STE. 204 CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Lynn B. Galt

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 05925

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT JAMES MESSERMAN

2. Date of Death

Month Day Year  
Feb. 15, 2011

3. Time of Death

6:13 P<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

193-14-6279

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
1/9/1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD.

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1231 Conowingo Road

10f. Zip Code

21014

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Store Manager

16b. Kind of Business Industry

Paint Supplies

17. Father's Name (First, Middle, Last)

Homer

Messerman

18. Mother's Name (First, Middle, Maiden Surname)

Grace

(unknown)

19a. Informant's Name/Relationship (Type, Print)

Clifford Tellis (Stepson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2201 Banks Street Baltimore, MD. 21231

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

Feb. 17, 2011

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

M. Madden Ruff

22. Name and Address of Facility

E.G. Kurtz &amp; Son Funeral Home, P.A. Jarrettsville, Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Jones

29c. License number

R149792

29d. Date signed (Month, Day, Year)

2/16/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

J. Jones

State  
RegistrarFEBRUARY 15, 2011 6:13 p.m.  
Baltimore, Maryland 21215-0036ROBERT MESSERMAN  
Division of Vital Records, P.O. Box 687603  
2/16To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05926

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Viola

May

Piper

2. Date of Death

Month

Day

3. Time of Death

February 5, 2011

7:43 A<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Western MD Regional Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

212-32-8148

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
08/03/1929

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11709 Homewood Street, NW

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business Industry

Retail

17. Father's Name (First, Middle, Last)

Robert

Charles

Butts

18. Mother's Name (First, Middle, Maiden Surname)

Emma

May

Albright

19a. Informant's Name/Relationship (Type, Print)

Christina L. Piper/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11709 Homewood Street, NW, Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hartsock Cemetery

Date

02/09/2011

20c. Location - City or Town, State

Oldtown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD 21502

Physician/  
Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

- Cardiopulmonary arrest

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

- Hypertension

b. Due to (or as a consequence of):

- Atherosclerotic Cardiovascular disease

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RO87737

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tom Bostaph, CRNP, 600 Memorial Avenue, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 25 per med cert 6913 3/11/11 dk  
State of Maryland / Department of Health and Mental Hygiene

2011 05927

1 For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ANTHONY EDWARD PIZZA</b>  |  |   |  | 2. Date of Death<br><b>FEBRUARY 10 2011</b>   |  | 3. Time of Death<br><b>08:00 PM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>VA MARYLAND HEALTH CARE SYSTEM</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>PERRY POINT</b>  |  | 4c. County of Death<br><b>PEERL</b>                                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>151-12-3212</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 16, 1924</b>             |  |
|   | 9. Birthplace (State or Foreign)<br><b>HACKENSACK NEW JERSEY</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CECIL</b>   |  | 10c. City, Town or Location<br><b>PERRY POINT</b>                       |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>PERRY POINT VA MEDICAL CENTER</b>  |  | 10f. Zip Code<br><b>21902</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>ARMY</b><br>If Yes, Give Year or Dates <b>1943-45</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DISABLED VETERAN</b>  |  | 16b. Kind of Business Industry<br><b>NEVER EMPLOYED</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH PIZZA</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY SELLAROLE</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>THERESA HELMER / SISTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3827 LAKE DRIVE UNIT 1049 SELEBYVILLE, DELAWARE 19975</b>                                     |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH'S CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>HACKENSACK, NEW JERSEY</b>  |  | 20d. Date<br><b>FEBRUARY 18, 2011</b>                                   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>CROUCH FUNERAL HOME, P.A.<br/>127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901</b>  |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ASPIRATION PNEUMONIA</b>  |  |   |  |   |  |   |  |
|   | 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> |  |   |  |   |  |   |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |
| 23d. Date of delivery<br>Month Day Year   |  |  |   |  |   |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   |  |   |  |   |  |
| 28a. Date of injury (Month, Day, Year)  |  |  |   |  |   |  |   |  |
| 28b. Time of injury<br><b>M</b>   |  |  |   |  |   |  |   |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |   |  |   |  |
| 28d. Describe how injury occurred   |  |  |   |  |   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |  |  |   |  |   |  |   |  |
| 29c. License number<br><b>MD 072692L</b>  |  |  |   |  |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>2/10/11</b>   |  |  |   |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DEBORAH BULLOCK, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902</b>   |  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |  |  |   |  |   |  |   |  |
| 32. Registrar's Signature<br>   |  |  |   |  |   |  |   |  |

NAME KNOWN TO PHYSICIAN: PIZZA, ANTHONY E.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

6+IVA

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05928

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma Elizabeth Taylor Prevour

2. Date of Death

Month Day Year  
Feb. 5, 2011

3. Time of Death

16:51 P<sup>M</sup>Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

578-32-9480

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 29, 1920

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6200 Edward Drive

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Secretary

16b. Kind of Business Industry

U S Government

17. Father's Name (First, Middle, Last)

John Hillary Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Augusta Clark

19a. Informant's Name/Relationship (Type, Print)

Ada M. Prevour - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6200 Edward Drive, Clinton, MD 20735

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Riverdale Crematory

Date

2/12/2011

20c. Location - City or Town, State

Riverdale Park, MD

21. Signature of Funeral Service Licensee

Judith K. Johnson

22. Name and Address of Facility

J. K. Johnson Funeral Home, P. A.  
6503 Old Branch Ave., Temple Hills, MD 2074823a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY HYPERTENSION  
SEVERE VALVULAR DISEASE (MITRAL +  
TRICUSPID REGURGITATION)

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29d. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature] PHYSICIAN

29c. License number

D53782

29d. Date signed (Month, Day, Year)

Feb 8<sup>th</sup> 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH VERGHESE MD, 17701 LIVINGSTON ROAD, SUITE 101, FT. WASH.

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

MD 20744

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerPhysician/  
Medical  
ExaminerFuneral  
DirectorState  
Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
Registrar

2011 05929

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JoAnn Phelps-Shannon

2. Date of Death

February 6 2011

3. Time of Death

12:15P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

5. Social Security Number

578-52-9869

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

8. Date of Birth (Month, Day, Year)

January 25, 1939

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2486 Quadrille Court

10f. Zip Code

20602

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give full work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business Industry

Elementary

17. Father's Name (First, Middle, Last)

Joseph A. McNamara

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Bauman

19a. Informant's Name/Relationship (Type, Print)

Lorraine Phelps/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5500 Taylor Road, Riverdale, MD 20737

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols Crem.

Date

2/9/2011

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.

211 St. Mary's Ave. La Plata, MD 20646

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Disseminated intravascular coagulation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cirrhosis of liver

Due to (or as a consequence of):

c. Bleeding duodenal ulcer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 45737

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nirmaladevi Jayanthan MD 3328 Old Washington Rd. Waldorf, MD 20602

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05930

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Patricia Lillian Pinto

2. Date of Death

February 9 2011

3. Time of Death

6:10 a M

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

212-30-5074

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03/19/1933

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6336 Cedar Lane #102

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ernest Brandenburg

18. Mother's Name (First, Middle, Maiden Surname)

Helen Baker

19a. Informant's Name/Relationship (Type, Print)

Debbie Trumbull - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7224 Second Time Lane Columbia, MD 21046

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ardent Crematory

Date

02/12/2011

20c. Location - City or Town, State

Hanover, MD

21. Signature of Funeral Service Licensee

Andre Amato

22. Name and Address of Facility

Harry H. Witzke's Family F.H.Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Chronic Obstructive Pulmonary Disease

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D47447

29d. Date signed (Month, Day, Year)

Feb 9, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andy Garris 6334 Cedar Lane Columbia, Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 10 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division or Vital Records, P.O. Box 68760,

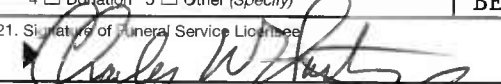
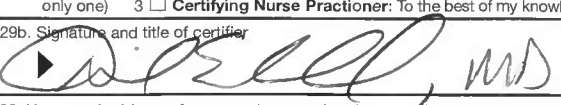

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EDITH L. PHILLIPS</b>   |  |   |  | 2. Date of Death<br>Month <b>FEB.</b> Day <b>8</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>5:50 P M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>8868 BETHEL ROAD</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>WILLARDS</b>   |  | 4c. County of Death<br><b>WICOMICO</b>  |  |
| 5. Social Security Number<br><b>217-01-8681</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>91</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 14, 1919</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | Usual Residence of Decedent   |  |   |  |   |  |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>WICOMICO</b>  |  | 10c. City, Town or Location<br><b>WILLARDS</b>  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>8868 BETHEL ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21874</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OWNER/OPERATOR</b>  |  | 16b. Kind of Business Industry<br><b>GENERAL STORE</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>WALTER H. LEWIS</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>OLEVIA M. BRADFORD</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHARON L. TAYLOR/GRANDDAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8868 BETHEL ROAD, WILLARDS, MARYLAND 21874</b>  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETHEL CEMETERY</b>  |  | Date<br><b>2/12/11</b>  |  | 20c. Location - City or Town, State<br><b>WILLARDS, MARYLAND</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>   |  |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiovascular pathology</b><br>Due to (or as a consequence of):   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):  |  |   |  |   |  |   |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |   |  |
| d. Due to (or as a consequence of):  |  |   |  |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown   |  |   |  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>6 <input type="checkbox"/> Unknown |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><br><b>DAVID COWALL, MD</b>  |  |   |  | 29c. License number<br><b>D26278</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2-9-11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID COWALL, MD Coastal Hospice PO Box 1733 Seals, MD 21802</b>  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

#25 Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05932

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |  |   |  |
|--|--|---|---|--|---|--|---|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Vera Elizabeth Teresa Pfaff</b>   |   |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>7</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>7:34 a</b> M                                     |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>St. Vincent Care Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Emmitsburg</b>   |  | 4c. County of Death<br><b>Frederick</b>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-01-8922</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 21, 1919</b>              |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |  |   |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   |   |  |   |  |   |  |
|  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Emmitsburg</b>  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>335 South Seton Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21727</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>5+</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietician</b>                         |  | 16b. Kind of Business Industry<br><b>Religious Community Daughters of Charity</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John J. Pfaff</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Teresa Fortman</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sister Sandra Goldsborough Servant</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>333 South Seton Avenue, Emmitsburg, MD 21727</b>  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery or other place)<br><b>St. Joseph's Provincial House</b>   |  | Date<br><b>2/11/2011</b>  |  | 20c. Location - City or Town, State<br><b>Emmitsburg, MD</b>            |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  | 22. Name and Address of Facility<br><b>Myers-Durboraw Funeral Home<br/>210 W Main St, Emmitsburg, MD 21727</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>End Stage Dementia</b><br>Approximate Interval Between Onset and Death<br><b>6 years</b> |   |   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.  |  |   |   |  |   |  |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  |   | 23d. Date of delivery<br>Month Day Year  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerosis<br/>Peripheral Vascular Disease</b>   |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Donita V. Kneupel-Portierdo</b>  |  |   |   | 29c. License number<br><b>40044037</b>                                       |   | 29d. Date signed (Month, Day, Year)<br><b>02-07-2011</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Donita V. Kneupel-Portierdo 121-123 West Main St, Reak Emmitsburg, MD 21727</b>   |  |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |  |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05933

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY Bottomley Pearson

2. Date of Death

Feb 19 2011

3. Time of Death

1074 M

4a. Facility Name (if not institution, give street and number)

Chester River Hospital

4b. City, Town, or Location of Death

Chester town

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

214-32-0387

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

96

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 24 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Millington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

120 Pfalzgroff Rd.

10f. Zip Code

21651

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Bottomley

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Pinion

19a. Informant's Name/Relationship (Type, Print)

Roger Pearson (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2953 Clayton-Delaney Rd. Clayton, DE. 19938

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Asbury Cemetery

Date

2/23/11

20c. Location - City or Town, State

Millington, MD.

21. Signature of Funeral Service Provider

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen L. Schaeck  
118 West Cross St. Galena, MD. 21635

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. DEXTRO KYPHOSCOLIOSIS

Due to (or as a consequence of):

b. BULLOUS LUNG DISEASE

Due to (or as a consequence of):

c. RESTRICTIVE LUNG DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0071130

29d. Date signed (Month, Day, Year)

2/19/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOR1 JACOBS 100 BROWN STREET CHESTERTOWN MD 21620

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Dennis A. Gave

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05934

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Ann Propst

2. Date of Death

Feb 19, 2011

3. Time of Death  
1911 M

4a. Facility Name (if not institution, give street and number)

WMHS-RMC

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

214-36-6335

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 6, 1940

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

235 Paca St. Apt. 901

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business Industry

own home

17. Father's Name (First, Middle, Last)

Lloyd Nathaniel Twigg

18. Mother's Name (First, Middle, Maiden Surname)

Naomi (Bohrer) Twigg

19a. Informant's Name/Relationship (Type, Print)

Pamela Dolly

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 3 Box 353

Ridgeley

WV 26753

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Scarpelli Funeral Home, P.A.

Date

2/21/2011

20c. Location - City or Town, State

Cresaptown MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA  
108 Virginia Avenue, Cumberland, MD 2150223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ARRYTHMIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 Hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Unknown

c. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

23e. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Mellitus  
Diabetic Renal Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31875

29d. Date signed (Month, Day, Year)

FEBRUARY 19 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT WELIK M.D. 12502 WILLOWBROOK RD. STE. 450 CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
Examiner

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05935

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><i>Henrietta C Robinette</i>   |  | 2. Date of Death<br>Month <i>January</i> Day <i>30</i> Year <i>2011</i>   |  | 3. Time of Death<br><i>12:05 pm</i> M   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>THE LIONS CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>   |  | 4c. County of Death<br><b>ALLEGANY</b>  |   |
| 5. Social Security Number<br><b>217-10-4622</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  |   |
| 8. Date of Birth (Month, Day, Year)<br><b>11/27/1914</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  |   |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>ALLEGANY</b>  |  | 10c. City, Town or Location<br><b>CORRIGANVILLE</b>   |   |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>10595 MT. SAVAGE ROAD, N.W.</b>  |  | 10f. Zip Code<br><b>21524</b>   |   |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>HOME</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>HARVEY M. BITTNER</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY S. KROUSHAUR</b>   |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CAROLYN L. ROBERTSON / DAU.</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10015 SHINNAMON DRIVE, S.W., LAVALE, MD 21502</b>   |  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RESTLAWN MEML. GARDENS</b>   |  | 20c. Location - City or Town, State<br><b>LAVALE, MD</b>  |   |
| 20d. Date<br><b>02/04/2011</b>   |  |   |  |   |   |
| 21. Signature of Funeral Service Licensee<br><i>George A. Lipek</i>  |  | 22. Name and Address of Facility<br><b>UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE STREET, CUMBERLAND, MD 21502</b>  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Cancer of ovary</b><br>Due to (or as a consequence of):<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |   | Approximate Interval Between Onset and Death<br><b>6 months</b>   |
| 23b. IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |   |
| 29b. Signature and title of certifier<br><i>WONWOCK SHEN MD</i>  |  | 29c. License number<br><b>D0055325</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Jan 31, 2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WONWOCK SHEN 925 Bishop Walsh Rd Cumberland MD 21502</b>  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 03 2011</b>  |  | 32. Registrar's Signature<br><i>Debra B. Gove</i>   |  |   |   |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

JMS

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05936

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Frank Louis Rubala</b>  |  |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>9</b> Year <b>2011</b>   |  |  |  | 3. Time of Death<br><b>11:31 p.m.</b>  |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  |  |  | 4c. County of Death<br><b>Calvert</b>  |  |  |  |
| 5. Social Security Number<br><b>282-14-0460</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>02/19/1921</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Mechanicsville</b>  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>28100 Thompson Corner Road</b>  |  |   |  | 10f. Zip Code<br><b>20659</b>   |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  |  |  | 16b. Kind of Business Industry<br><b>Banking</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Mike Rubala</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Onachilla</b> |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marjorie Rubala/Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28100 Thompson Corner Road, Mechanicsville, MD 20659</b>  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Memorial</b>   |  | Date<br><b>02/14/2011</b>  |  | 20c. Location - City or Town, State<br><b>Waldorf, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Edward N. Brinsfield, Jr. M00052</b>   |  |   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>  |  |  |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>CAD</b><br>Due to (or as a consequence of):<br><b>OSTEOCYTOSIS</b><br>Due to (or as a consequence of):<br><b>ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>HYPOXIA</b>   |  |   |  |   |  |  |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |   |  |   |  |  |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Harshinder Sidhu MD</b>  |  |   |  | 29c. License number<br><b>D 70855</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>2/10/11</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harshinder Singh Sidhu, M.D. 100 Hospital Road, Prince Frederick, MD 20678</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 15 2011</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |  |  |

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#29d per MD, 2/8/11, FCHD Certificate of Death LE

Reg. No.

2011 05937

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clyde Edward Rhea

2. Date of Death

January 28, 2011

3. Time of Death

2310M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-34-1081

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 28, 1939

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

West VA

10b. County

Berkley

10c. City, Town or Location

Hedgesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1245 Koontztown Road

10f. Zip Code

25427

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vice President

16b. Kind of Business Industry

Banking

17. Father's Name (First, Middle, Last)

Andrew Jackson Rhea

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Little

19a. Informant's Name/Relationship (Type, Print)

Patricia Rhea / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1245 Koontztown Road, Hedgesville, West Virginia 25427

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery Burkittsville

Date

1/4/2011

20c. Location - City or Town, State

Burkittsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home, P.A.  
1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD, HTN, ARRHYTHMIA  
SIP IACD, CHF

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0665024

29d. Date signed (Month, Day, Year)

1/31/2011 1/31/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONIQUE GOMA 1116 Medical Campus Rd. Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05938

1- For  
State  
Registrar

|   |   |  |   |                                      |   |  |  |   |  |  |
|---|---|--|---|--------------------------------------|---|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Virginia Marylue Robinson</b>  |  |   |                                      | 2. Date of Death<br>Month: <b>02</b> Day: <b>02</b> Year: <b>11</b>   |  |  |   | 3. Time of Death<br><b>1958P</b> M   |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Prince Georges Hospital</b>  |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  |  |   | 4c. County of Death<br><b>Prince Georges</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>123-32-0504</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1933</b>                            |   | 9. Birthplace (State or Foreign Country)<br><b>Roxboro, N.C.</b>   |  |
|   | Usual Residence of Decedent   |  |   |                                      |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince Georges</b>  |                                      | 10c. City, Town or Location<br><b>Capitol Heights</b>   |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>405 Rollins Avenue</b>   |  |   |                                      | 10f. Zip Code<br><b>20743</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                                |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)   |  |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Bus Aide</b>   |  |  | 16b. Kind of Business Industry<br><b>P.G. County Schools</b>            |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Samuel Winstead</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mahaley Smith</b>   |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Wendy Robinson / Daughter</b>  |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>405 Rollins Avenue Capitol Heights, Md. 20743</b>   |  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington National</b>  |                                      | Date<br><b>2/12/2011</b>  |  | 20c. Location - City or Town, State<br><b>Suitland, Md.</b>                          |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |                                      | 22. Name and Address of Facility<br><b>Alexander S. Pope, P.A.<br/>5538 Marlboro Pike / Forestville, Md. 20747</b>  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Anoxic Brain Injury</b><br>Due to (or as a consequence of):<br>b. <b>Respiratory Failure</b><br>Due to (or as a consequence of):<br>c. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>d. <b>Pulmonary Fibrosis</b>   |  |   |                                      |   |  |  |   |  |  |
|   | Approximate Interval Between Onset and Death  |  |   |                                      |   |  |  |   |  |  |
| Physician/<br>Medical<br>Examiner   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |                                      |   |  |  |   |  |  |
|   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)   |  |   |                                      |   |  |  |   |  |  |
|   | 23d. Date of delivery<br>Month Day Year   |  |   |                                      |   |  |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                      |   |  |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |   |  |   |                                      |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |   |  |   |                                      |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                      |   |  |  |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |                                      | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                      |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |   | 29c. License number<br><b>269552</b> |   | 29d. Date signed (Month, Day, Year)<br><b>February 3, 2011</b> |  |   |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Claudia Austin MD 3001 Hospital Dr Cheverly MD 20785</b> |   |  |   |                                      |   |  |  |   |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |  |   |                                      | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05939

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Effie L. Rogers

2. Date of Death  
Month Day Year

February 3, 2011

3. Time of Death

10:33P M

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

155-24-6730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months

Days

Hours

Min.

8. Date of Birth

June 8, 1914

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

MD

10b. County

PG

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9005 Anna Drive

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business Industry

Lighting Company

17. Father's Name (First, Middle, Last)

Rufus Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Hinton

19a. Informant's Name/Relationship (Type, Print)

Natalie Bruce/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9005 Anna Drive

Clinton, MD. 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beautiful Zion AME Church Cem. Tuscaloosa, AL

Date

2/12/11

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janice Edwards

22. Name and Address of Facility

Hodges & Edwards F.H.  
3910 Silver Hill Rd., Suitland, Md. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Pericarditis

Due to (or as a consequence of):

c. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

d. Anemia

Approximate Interval Between Onset and Death

Unknown

Unknown

Unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sacroiliac  
Pneumonia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Janice Edwards

29c. License number

50454

29d. Date signed (Month, Day, Year)

Feb. 5, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9135 Piskunoff Rd Suite 235 Clinton MD 20735

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Janice Edwards

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Medical Certificate: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- For Amend Items 25, 27, 28a-f per me 8912.02/25/2011dhb  
 Registrar Certificate of Death 2011 05940  
 Reg. No.

Baltimore, Maryland 21215-0036

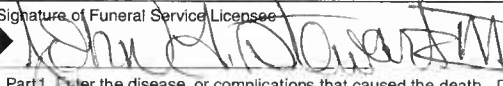

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Gilbert C. Shaw Sr.</b>   |  | 2. Date of Death<br>Month Day Year<br><b>January 18, 2011</b>   |   | 3. Time of Death<br><b>0640 A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |   | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>578-20-8380</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 15, 1924</b>                     | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |
| Usual Residence of Decedent  |  |   |   |   |  |
| 10a. State<br><b>DC</b>  | 10b. County  | 10c. City, Town or Location<br><b>Washington</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>4347 C Street SE</b>  |  | 10f. Zip Code<br><b>20019</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>5th</b>   |   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Foreman</b>  |  | 16b. Kind of Business/Industry<br><b>Government</b>   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Connie Shaw</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Bell Randolph</b> |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Deborah M. Bell - Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3305 Altair Lane Upper Marlboro, Md. 20774</b>  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln</b>  |   | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019</b>   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br><b>b. Bilateral (Subdural) Hematoma with Herniate</b><br>Due to (or as a consequence of):<br><b>c. Metastatic Prostate Cancer</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |   |  |
| 23b. If female:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Unknown   |  |   |   |   |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>12/22/2010</b>   |   | 28b. Time of Injury<br><b>9:20 p. M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Subject fell</b>  |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Hospital</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1500 Forest Glen Rd., Silver Spring, MD</b>  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0055856</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>January 21, 2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Negash Ayele M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910-1484</b>  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 26 2011</b>  |  | 32. Registrar's Signature<br>  |   |   |  |



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05941

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard L. Somerville

2. Date of Death

Feb. 7 2011

3. Time of Death

17:17P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

23490 Budds Creek Road

4b. City, Town, or Location of Death

Clements

4c. County of Death

St. Mary's

5. Social Security Number

219 46 7014

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 25, 1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Clements

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

23490 Budds Creek Road

10f. Zip Code

20624

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

1966-68

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Welder

16b. Kind of Business Industry

US Government

17. Father's Name (First, Middle, Last)

Joseph Columbus Somerville

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice L. Somerville

19a. Informant's Name/Relationship (Type, Print)

Dominique Somerville/Daug.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4222 Massachusettes Ave. Wash. DC SE 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Queen of Peace Cem.

Date

2/14/2011

20c. Location - City or Town, State

Helen, MD

21. Signature of Funeral Service Licensee

Dominique Somerville

22. Name and Address of Facility

Briscoe-Tonic Funeral Home

2294 Old Washington Rd. Waldorf, MD 20601

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIABETES MELLITUS type 2

Due to (or as a consequence of):

25 YRS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending2 ☐ Accident 6 ☐ Investigation3 ☐ Suicide 6 ☐ Could not be4 ☐ Homicide 6 ☐ determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert J. Baumann MD

29c. License number

D0014168

29d. Date signed (Month, Day, Year)

2-8-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT J. BAUMANN 2103 THREE NOTCH RD SUITE 101 MIDDLEBURGH, MD 20653

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Anna B. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

7B24



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05942

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |   |  |   |
|---|--|---|---|--|---|---|--|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Brenda Lou Schultz</b>  |   |   |  | 2. Date of Death<br>Month <b>Feb.</b> Day <b>7</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>0626</b> M  |   |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Peninsula Regional Medical Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>  |   | 4c. County of Death<br><b>Wicomico</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-46-2577</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>2/5/1946</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|   | Usual Residence of Decedent  |   |   |  |   |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Wicomico</b>  |  | 10c. City, Town or Location<br><b>Salisbury</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>31459 Spearin Rd.</b>   |   |   |  | 10f. Zip Code<br><b>21804</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business Industry<br><b>Own Home</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Phillips</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hilda Layton</b>  |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Andrew Schultz / husband</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>31459 Spearin Rd., Salisbury, MD 21804</b>  |   |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>First State Crem.</b>  |  | Date<br><b>2/9/2011</b>   |   | 20c. Location - City or Town, State<br><b>Millsboro, DE</b>  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |   |   |  | 22. Name and Address of Facility<br><b>Burbage Funeral Home<br/>108 William St., Berlin, MD 21811</b>   |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ASCD.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br><b>End-stage renal disease</b><br>b. Due to (or as a consequence of):<br><b>Hypertension</b><br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |   |  |   |
|   | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |  |   |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>                  |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28d. Describe how injury occurred                |   |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |   |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |   |  |   |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |   |   | 29c. License number<br><b>070129</b>             |   | 29d. Date signed (Month, Day, Year)<br><b>02/09/2011</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>IRFAN A. MOINUDDIN MD 100E. CARROLL ST. SALISBURY MD 21801</b>   |  |   |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 10 2011</b>   |  |   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |   |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

BA7

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05943

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Iraci L. Da Silva

2. Date of Death

Month 02 Day 06 Year 2011

3. Time of Death

8:31 AM

4a. Facility Name (if not institution, give street and number)

Peninsula Regional Medical Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

n/a

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
01/29/1951

9. Birthplace (State or Foreign Country)

Brazil

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Fruitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 Hayward Ave.

10f. Zip Code

21826

10g. Citizen of What Country?

Brazil

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Brazilian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

housewife

16b. Kind of Business Industry

domestic

17. Father's Name (First, Middle, Last)

Goncalves L. Silva

18. Mother's Name (First, Middle, Maiden Surname)

Maria R. DeAndrade

19a. Informant's Name/Relationship (Type, Print)

Walter DaSilva/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Hayward Ave, Fruitland MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Public Cemetery

Date

unknown

20c. Location - City or Town, State

Cuiete Velho, Brazil

21. Signature of Funeral Service Licensee

L. Blane

22. Home Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804Physician/  
Medical  
Examiner23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Brain Death

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Cerebral Vascular Accident

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

48 hr

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒  
2 ☐  
3 ☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James J Morgan MD

29c. License number

MD53825

29d. Date signed (Month, Day, Year)

2/6/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James J Morgan MD 100E. CARROLL ST. Salisbury Md 21801

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Anna B. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05944

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Violet Blake Showell

2. Date of Death

Month Day Year  
02 07 2011

3. Time of Death

15:10 PM

4a. Facility Name (if not institution, give street and number)

PENNSYLVANIA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

HAMILTON

Funeral  
Director

5. Social Security Number

220-28-2380

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

8. Date of Birth (Month, Day, Year)

Jan 17, 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Snow Hill

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

205 Commerce Street

10f. Zip Code

21863

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Certified Nursing Assistant

16b. Kind of Business Industry

Nursing Home

17. Father's Name (First, Middle, Last)

George Blake

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ayres

19a. Informant's Name/Relationship (Type, Print)

George Washington Blake/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4035 Gravel Hill Rd., Havre De Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Wesley UMC Cem

Date

02/12/11

20c. Location - City or Town, State

Snow Hill, MD

21. Signature of Funeral Service Licensee

Jalana Watson

22. Name and Address of Facility

Lewis N. Watson Funeral Home, PA  
1618 West Rd., Salisbury, MD 21801

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Insufficiency  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Renal Disease  
Type 2 Diabetes Mellitus  
Essential Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

C. Ernest Gibbs Jr M.D.

29c. License number

D0063253

29d. Date signed (Month, Day, Year)

2-7-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clyde Ernest Gibbs Jr M.D. 428 W. Market St., Snow Hill, MD 21863

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Anna A. Spivey

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05945

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leslie A. Snyder

2. Date of Death

Month 02 Day 08 Year 2011

3. Time of Death

8:45 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Coastal Hospice at the Lake

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

208-36-7008

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

63 Yrs.

8. Date of Birth

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)

6-27-1947

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Nanticoke

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20422 Nanticoke Drive

10f. Zip Code

21840

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Food Managements

16b. Kind of Business Industry

Food Services

17. Father's Name (First, Middle, Last)

Lester B. Antes

18. Mother's Name (First, Middle, Maiden Surname)

Edith Palmer

19a. Informant's Name/Relationship (Type, Print)

Frank Antes - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4498 Sunset Drive, Tyaskin, Maryland 21865

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Turner's Cemetery

Date

2-10-2011

20c. Location - City or Town, State

Nanticoke, Maryland

21. Signature of Funeral Service Licensee

Melissa Henry Blake

22. Name and Address of Facility

Bounds Funeral Home

705 E. Main Street, Salisbury, Maryland 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT LUNG CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No

M

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D0058410

29d. Date signed (Month, Day, Year)

02-08-11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gethiam Warys 1733 Salisbury MD 21802

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

State  
RegistrarLeslie Snyder  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05946

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jason E. Sanders

2. Date of Death

February 7, 2011

3. Time of Death

11:56 a M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Catherine's Nursing Center

4b. City, Town, or Location of Death

Emmitsburg

4c. County of Death

Frederick

5. Social Security Number

190-12-2530

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

8. Date of Birth

Nov 4, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick

10c. City, Town or Location

Emmitsburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

331 South Seton Avenue

10f. Zip Code

21727

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Plumbing

17. Father's Name (First, Middle, Last)

Jason M. Sanders

18. Mother's Name (First, Middle, Maiden Surname)

Lottie Reed

19a. Informant's Name/Relationship (Type, Print)

Joyce Valentine, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

224 Tyrone Circle, Baltimore MD 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

South Carroll Crematory

Date

2/8/2011

20c. Location - City or Town, State

Winfield, MD

21. Signature of Funeral Service Licensee

Just R. Durboraw

22. Name and Address of Facility

Myers-Durboraw Funeral Home

210 W Main St, Emmitsburg, MD 21727

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Dementia - end stage

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

Renal Failure

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A.L. Carroll MD

29c. License number

D0018705

29d. Date signed (Month, Day, Year)

2/7/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.L. CARROLL, M.D. 310 SOUTH SETON AVE. EMMITTSBURG, MD 21727

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

Kenna S. Spivey

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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WJL  
3+IVA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05947

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Verne Simkins

2. Date of Death

February 7, 2011

3. Time of Death

12:00 P M

4a. Facility Name (If not institution, give street and number)

133 Penny Ln.

4b. City, Town, or Location of Death

Stevensville

4c. County of Death

Queen Anne's

5. Social Security Number

217-44-3132

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

8. Date of Birth

March 3, 1947

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

133 Penny Ln.

10f. Zip Code

21666

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business Industry

Truck

17. Father's Name (First, Middle, Last)

Robert Simkins

18. Mother's Name (First, Middle, Maiden Surname)

Hilda Glover

19a. Informant's Name/Relationship (Type, Print)

Betty F. Simkins / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

133 Penny Ln., Stevensville, MD 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kalas Crematory

Date

2/11/2011

20c. Location - City or Town, State

Edgewater, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd., Edgewater, MD 21037

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer

Due to (or as a consequence of):

b. Tobacco abuse

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Throat Cancer 2005

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elizabeth Schilling CRNP

29c. License number

R082434

29d. Date signed (Month, Day, Year)

2/7/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH SCHILLING CRNP 115 Sallitt Dr. Suite E Stevensville MD 21666

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05948

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Lee Sopko

2. Date of Death

February 06, 2011

3. Time of Death

9:00 A<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

Tate Chesapeake Hospice House

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

214-56-0463

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

8. Date of Birth

Feb. 07, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

31 Smith Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tax Collector

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Emma Marie Collins

19a. Informant's Name/Relationship (Type, Print)

Brenda Muzik / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7750 Rockanna Road Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, INC.

Date

February 08, 2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinosarcoma of uterus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, type I  
Lupus

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice Home

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

DS2830

29d. Date signed (Month, Day, Year)

February 7, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeanine Werner, MD, 203 Medical Parkway #210, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05949

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |   |   |   |                                      |   |  |   |   |  |  |
|--|---|---|---|--------------------------------------|---|--|---|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>KAREN SMITH</b>  |   |   |                                      |   |  | 2. Date of Death<br>Month <b>February</b> Day <b>4</b> Year <b>2011</b>   |   | 3. Time of Death<br><b>6:15 A<sup>M</sup></b>  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Laurel Regional Hospital</b>   |   |   |                                      |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |   | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-88-5699</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 12 1959</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>                                  |  |
|  | Usual Residence of Decedent   |   |   |                                      |   |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>PRINCE GEORGE'S</b>   |                                      | 10c. City, Town or Location<br><b>LAUREL</b>  |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>9001 CHERRY LANE</b>   |   |   |                                      | 10f. Zip Code<br><b>20708</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>DISABLED</b>  |   |   |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DISABLED</b>  |  |   | 16b. Kind of Business Industry<br><b>NONE</b>                           |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN SMITH</b>  |   |   |                                      |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALETHA MAE CASE</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ANGEL HEARD/DGT</b>  |   |   |                                      |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2140 BROOKS DRYE #308 FORESTVILLE, MARYLAND 20747</b> |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RIVERDALE CREMATORY</b>  |                                      | Date<br><b>2/9/2011</b>   |  | 20c. Location - City or Town, State<br><b>RIVERDALE, MARYLAND</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |                                      |   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME, INC.<br/>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>                            |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Intracranial Bleed</b><br>Due to (or as a consequence of):<br><b>Cerebral Edema</b><br>Sequentially list conditions, starting with the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. <b>Intracranial Bleed</b><br>Due to (or as a consequence of):<br>b. <b>Cerebral Edema</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |   |   |                                      |   |  |   |   |  |  |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input checked="" type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |   |   |                                      |   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Diabetes Mellitus</b><br><b>Encephalopathy</b>   |   |   |   |                                      |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                      |   |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>      |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>D70093</b> |   | 29d. Date signed (Month, Day, Year)<br><b>02/04/2011</b>   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SARITHA GOPANTLA</b><br><b>7300 Van Dusen Rd. Laurel, MD 20707</b>  |   |   |   |                                      |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |                                      |   |  |   |   |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05950

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

A D Smith

2. Date of Death

Month 02 Day 06 Year 2011

3. Time of Death

5:05 P M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

252-30-2063

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 03/21/1926

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

708 Iona Terrace

10f. Zip Code

20743

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates. 1944-1944

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Taxi Cab Driver

16b. Kind of Business Industry

Diamond Cab

17. Father's Name (First, Middle, Last)

Ike Smith

18. Mother's Name (First, Middle, Maiden Surname)

Flemmie Lee Grier

19a. Informant's Name/Relationship (Type, Print)

Nichelle White/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Iona Terrace Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

02/17/2011

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Nuan Frederick

22. Name and Address of Facility

Marshall-March Funeral Home  
4308 Suitland Road Suitland, MD 20746

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Severe Dementia

Due to (or as a consequence of):

Hypernatremia

Due to (or as a consequence of):

Cardiopulmonary Arrest

Due to (or as a consequence of):

Cerebral Vascular Accident

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Aniedobe

29c. License number

D66162

29d. Date signed (Month, Day, Year)

02-06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edith Aniedobe 1500 Forest Glen Road Silver Spring, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward A. Simmons

2. Date of Death

February 6, 2011

3. Time of Death

22:21 P M

4a. Facility Name (if not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

237-46-0540

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 8, 1932

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3809 St. Barnabas Road # 204

10f. Zip Code

20746

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

United States Post Office

16b. Kind of Business Industry

Government

17. Father's Name (First, Middle, Last)

Charlie Simmons

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Davis

19a. Informant's Name/Relationship (Type, Print)

Avegene L. Simmons - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3809 St. Barnabas Road # 204 Suitland, Maryland 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln

Date

February 12, 2011

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS SYNDROME

Due to (or as a consequence of):

b. RESPIRATORY FAILURE

Due to (or as a consequence of):

c. ASPIRATION PNEUMONITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASHEED A. ABASSI @ 7503 SURREATTS ROAD - CLINTON MD 20735

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician/  
Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

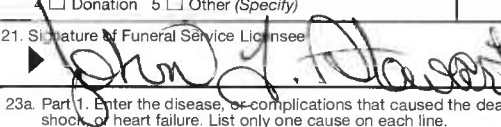
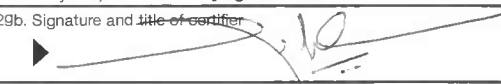

State of Maryland / Department of Health and Mental Hygiene

2011 05952

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Anthony Scott</b>  |   | 2. Date of Death<br>Month <b>February</b> Day <b>5</b> , Year <b>2011</b>   |  | 3. Time of Death<br><b>7:00 PM</b>  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>St. Thomas More Nursing Home</b>   |   | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>  |  | 4c. County of Death<br><b>Prince George's</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-88-8370</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 2, 1958</b>   | 9. Birthplace (State or Foreign Country)<br><b>DC</b>   |
|   | Usual Residence of Decedent   |   |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>   | 10c. City, Town or Location<br><b>Hyattsville</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>4103 72nd Avenue</b>   |   | 10f. Zip Code<br><b>20784</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b> |  |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Landscaping</b>   |   | 16b. Kind of Business Industry<br><b>Private</b>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>George Scott</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susie Bowie</b>   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susie White - Mother</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4103 72nd Avenue Hyattsville, Maryland 20784</b>      |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lee's Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Stewart Funeral Home, Inc.<br/>4001 Benning Road NE Washington, DC 20019</b>                                       |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Alleroclerostic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. <b>End Stage Renal Disease</b><br>Due to (or as a consequence of):<br>c. <b>Human Immunodeficiency Virus</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death |   |   |  |   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |   | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |   |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> <b>Certifying Nurse Practitioner:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |
| 29b. Signature and Title of Certifier<br>  |   | 29c. License number<br><b>Doo63681</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>February 10, 2011</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ajit Kurup, M.D. 1835 University Blvd. E # 208 Hyattsville Maryland 20783</b>  |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>FEB 14 2011</b>   |   | 32. Registrar's Signature<br>  |   |  |   |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

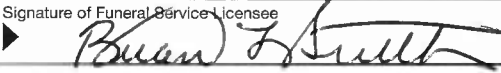
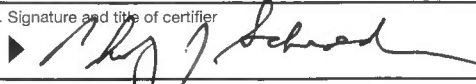
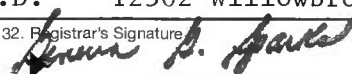
Medical Certificate: To Be Completed by Physician/Medical Examiner

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Norma Selene Shoemaker</b>  |  | 2. Date of Death<br>Month <b>2</b> Day <b>14</b> Year <b>11</b>   |  | 3. Time of Death<br><b>0920</b> M  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Western Maryland Regional Med. Ctr.</b>   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |  |
| 5. Social Security Number<br><b>234-48-3251</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>March 5, 1933</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Westernport, MD</b>  |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>WV</b>  |  | 10b. County<br><b>Mineral</b>   |  | 10c. City, Town or Location<br><b>Keyser</b>   |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>500 Carskadon Lane, Apt. 312</b>   |  | 10f. Zip Code<br><b>26726</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>   |  | 16b. Kind of Business Industry<br><b>Garment Manufacturing</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Norman K. Haywood</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie M. Groves</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ted Shoemaker/ Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 33 Burlington, WV 26710</b>   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>The Cumberland Crematory 2011</b>  |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Smith Funeral Home<br/>Rt. 2, Box 1-A Burlington, WV 26710</b>   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC ADENOCARCINOMA COLON</b><br>Due to (or as a consequence of):<br>b. <b>PULMONARY INSUFFICIENCY</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>14 DAYS</b><br><b>3 DAYS</b>  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide               |  | 28a. Date of injury (Month, Day, Year)<br><b>Feb. 16</b>   |  |
| 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>017456</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/14/2011</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Philip Schroeder, M.D. 12502 Willowbrook Road, Suite 580 Cumberland, MD 21502</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b>  |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05954

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anna M. Stevens

2. Date of Death

Feb 18, 2011

3. Time of Death

0540 M

4a. Facility Name (If not institution, give street and number)

Frostburg Village Nursing Home

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

5. Social Security Number

218-80-3468

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth (Month, Day, Year)

May 8, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 Kaylor Circle

10f. Zip Code

21532

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Welsh

18. Mother's Name (First, Middle, Maiden Surname)

Anna (Collins) Welsh

19a. Informant's Name/Relationship (Type, Print)

Michael Stevens

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 Schley Steet

Cumberland

MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Patrick's Cemetery

Date

2/21/2011

20c. Location - City or Town, State

Cumberland

MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Scarpelli Funeral Home, PA

108 Virginia Avenue, Cumberland, MD 21502

23a. Part I. Enter the cause(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARJIT SIDHU, M.D. 925 BISHOP WASH RD. CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05956

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Linda Jane Titchenell

2. Date of Death

Month Day Year  
02 01 2011

3. Time of Death

02:26AM

4a. Facility Name (If not institution, give street and number)

Western MD Regional Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

218-74-8124

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
02/07/1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

427 Walnut Street

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Home

17. Father's Name (First, Middle, Last)

William A. Walters, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edna Mae Lanam

19a. Informant's Name/Relationship (Type, Print)

Warren Lewis / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

445 Race Street, Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Ashby Cemetery

Date

02/05/2011

20c. Location - City or Town, State

Fort Ashby, WV

21. Signature of Funeral Service Licensee

► *Spengler Upchurch*

22. Name and Address of Facility

Upchurch Funeral Home, P.A.

202 Greene Street, Cumberland, MD 21502

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Septic shock

b. Due to (or as a consequence of):

Small cell lung Cancer.

c. Due to (or as a consequence of):

pancytopenia.

d. Due to (or as a consequence of):

COPD

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *B. Faris*

29c. License number

D66604

29d. Date signed (Month, Day, Year)

02/01/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BASHAR FARIS MD 12500 Willowbrook Rd, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

FEB 03 2011

32. Registrar's Signature

Dana A. Spahr

Baltimore, Maryland 21215-0036  
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

3  
NoState  
Registrar

1- For State Registrar

Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |
|---|---|--|---|--|--|--|
| Physician / Medical Examiner                  | 1. Decedent's Name (First, Middle, Last)<br><b>John</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>9</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>14:21 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death  |  |
| Funeral Director                              | 5. Social Security Number<br><b>218-32-7614</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>May 22, 1938</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Perryville</b>   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>1010 Cedar Corner Road</b>   |  | 10f. Zip-Code<br><b>21903</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| To Be Completed by Physician/Medical Examiner | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Twelve Years</b> College (1-4 or 5+) <b>College</b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chief of Food Production</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John C. Thomas</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Simpers</b>   |  | 16b. Kind of Business/Industry<br><b>V.A. Maryland Health Care System Perry Point, Maryland</b>  |  |
| Physician / Medical Examiner                  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rhonda B. Thomas (wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1010 Cedar Corner Road, Perryville, MD 21903</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R.A. Ferris &amp; Co., Inc.</b>  |  | 20c. Location - City or Town, State<br><b>West Chester, Pennsylvania</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Thomas M. Patterson, Sr.</i>  |  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home, P.A. Perryville, Maryland 21903-0766</b>  |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pulmonary Embolus</b><br>Due to (or as a consequence of):<br>b. <b>Deep Vein Thrombosis</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death  |  |  |  |
| To Be Completed by Physician/Medical Examiner | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unknown       |  | 23d. Date of delivery<br>Month Day Year  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   | 29a. Certifier<br>(check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Anthony Frattalone, MD</i>  |  | 29c. License number<br><b>RES-000</b>  |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 9, 2011</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anthony Frattalone 600 North Wolfe St, Baltimore, MD, 21287</b>  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>FEB 11 2011</b>   |  | 32. Registrar's Signature<br><i>Debra A. Davis</i>  |  |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

671VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Emory Tucker, Jr.

2. Date of Death

Month Day Year  
February 9, 2011

3. Time of Death

5:12 AM

4a. Facility Name (if not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-52-0119

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
January 2, 1934

9. Birthplace (State or Foreign Country)

Largo, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5605 Longfellow Street, #302

10f. Zip Code

20737

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1951-195313. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Landscaper

16b. Kind of Business Industry

Prince George's  
County Government

17. Father's Name (First, Middle, Last)

John Emory Tucker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen May Windsor

19a. Informant's Name/Relationship (Type, Print)

Barbara L. Tucker / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5605 Longfellow St., #302, Riverdale, MD 20737

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

2/12/2011

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

4739 Baltimore Avenue  
Gasch's Funeral Home, P.A. Hyattsville, MD 2078123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

CARDIAC ARRYTHMIA

a. Due to (or as a consequence of):

CONGESTIVE HEART FAILURE

b. Due to (or as a consequence of):

CORONARY ARTERY DISEASE

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-59284

29d. Date signed (Month, Day, Year)

02/10/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARON SATAMIN, MD, WASHINGTON ADVENTIST HOSP, TAKOMA PARK, MD-20912

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 14 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hazel Ruth Thomas</b>   |  | 2. Date of Death<br>Month <b>02</b> Day <b>16</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>1341 M</b>  |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>Meritus Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |   | 4c. County of Death<br><b>Washington</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-20-0893</b><br><b>219-12-1392</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 11, 1927</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>Washington</b>   | 10c. City, Town or Location<br><b>Hagerstown</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>12829 Little Elliott Drive Apt.4</b>  |  | 10f. Zip Code<br><b>21742</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>Packer</b>            |   |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Textile</b>  |  | 16b. Kind of Business Industry  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Robert Boyd Alter</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Blanche Booher</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy L. Shaoal/Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11029 Plumwood Circle, Hagerstown, MD 21742</b>   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>2/19/2011 Hagerstown, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>S. Mark Snipp</b>  |  | 22. Name and Address of Facility <b>Rest Haven Funeral Chapel</b><br><b>1601 Pennsylvania Ave., Hagerstown, MD 21742</b>                              |   |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Severe chronic obstructive disease</b><br>Due to (or as a consequence of):<br>b. <b>with ventilatory failure</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |
| Approximate Interval Between Onset and Death   |  |  |   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown<br>23d. Date of delivery<br>Month Day Year  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Atrial Fibrillation</b><br><b>Recurrent pleural effusions</b>   |  |  |   |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |   |   |  |
| 28a. Date of injury (Month, Day, Year)<br>28b. Time of injury<br><b>M</b><br>28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Francisco A. Daniel, DO</b><br>29c. License number<br><b>H0061117</b><br>29d. Date signed (Month, Day, Year)<br><b>February 16, 2011</b>   |  |  |   |   |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>Francisco A. Daniel, DO Meritus Medical Center, Hagerstown, MD</b>  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 25 2011</b><br>32. Registrar's Signature<br><b>James S. Spall</b>  |  |  |   |   |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

## Certificate of Death

1- For State Registrar

2011 05960

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ernestine Valenzano

2. Date of Death

Month Day Year  
February 03, 2011

3. Time of Death

03:40 PM M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frostburg Nursing &amp; Rehab Center

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

5. Social Security Number

216-14-1974

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
August 25, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Eckhart

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17219 Porter Road

10f. Zip Code

21528-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Textile Worker

16b. Kind of Business/Industry

Celanese Fiber Corp.

17. Father's Name (First, Middle, Last)

John Valenzano

18. Mother's Name (First, Middle, Maiden Surname)

Maria Sassone

19a. Informant's Name/Relationship (Type, Print)

John Valenzano Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

646 River Oak Court Salisbury Maryland 21801-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Saint Michael's Cemetery

Date

February 07, 2011

20c. Location - City or Town, State

Frostburg Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLORECTAL CARCINOMA

Due to (or as a consequence of):

Sequentially list conditions,

if they lead to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

026907

29d. Date signed (Month, Day, Year)

FEBRUARY 03, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Sidhu

925 Bishop Walsh Rd. Cumberland MD 21502

31. Date filed (Month, Day, Year)

FEB 07 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar AMEND#2 per PHY State of Maryland / Department of Health and Mental Hygiene 2011 05961  
 2/16/2011 AACO HEALTH CARE Certificate of Death Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN J. VANDEVER, JR

2. Date of Death

2/7/2011  
Month Day Year  
02 07 2011

3. Time of Death

2230 M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

8140 Riverside Drive

4b. City, Town, or Location of Death

Pasadena

4c. County of Death

Anne Arundel

5. Social Security Number

152-30-0831

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 20, 1940

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8140 Riverside Drive

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates. 1962-1982

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

17. Father's Name (First, Middle, Last)  
John J. Vandever

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Army Officer

16b. Kind of Business Industry

Military

18. Mother's Name (First, Middle, Maiden Surname)

Helen Elizabeth Poffenbarger

19a. Informant's Name/Relationship (Type, Print)

Judith C. Vandever / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8140 Riverside Drive Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, INC.

Date

February 8, 2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Ritchie Hwy, Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastroesophageal Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
Years

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Michael J. Lentam

29c. License number

D 21438

29d. Date signed (Month, Day, Year)

February 08 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. LENTAM 445 DEFENSE HWY ANNAPOLIS MD 21401

31. Date filed (Month, Day, Year)

FEB 09 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

ORIGINAL

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arlene Deanna Vann

2. Date of Death

February 16, 2011

3. Time of Death

0229 M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Meritus Medical Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

223-50-3980

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 14, 1938

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16417 Shinham Road

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business Industry

Textile

17. Father's Name (First, Middle, Last)

Ordra Racey

18. Mother's Name (First, Middle, Maiden Surname)

Laura Elizabeth Shell

19a. Informant's Name/Relationship (Type, Print)

Todd T. Vann/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11818 Clearview Rd., Hagerstown, MD 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

2/18/2011

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

S. Mark Swigg

22. Name and Address of Facility

Rest Haven Funeral Chapel

1601 Pennsylvania Ave., Hagerstown, MD 21742

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Primary Biliary Cirrhosis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Perforated Duodenal Ulcer, Chronic renal failure, Anemia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shahid Mahmood MD

29c. License number

D0063233

29d. Date signed (Month, Day, Year)

02/16/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

580 Northern Ave Hagerstown MD 21742

Shahid Mahmood MD

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

Shahid Mahmood

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annie L. Winebrenner

2. Date of Death

01 24 11

3. Time of Death

0645 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Western Maryland Regional Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

220-34-3578

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

January 04, 1935

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Mount Savage

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17000 Dutch Hollow Road

10f. Zip Code

21545-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0 College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Homemaker

17. Father's Name (First, Middle, Last)

William J. Collier

18. Mother's Name (First, Middle, Maiden Surname)

Goldie O. Shiftet

19a. Informant's Name/Relationship (Type, Print)

Bryan Winebrenner son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10945 Sugar Row Road Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veteran's Cemetery

Date

January 31, 2011

20c. Location - City or Town, State

Flintstone Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute respiratory failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

Sequentially list conditions  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

20 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
g ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic stroke, Cellulitis

23e. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas J. Devlin M.D.

29c. License number

D21458

29d. Date signed (Month, Day, Year)

January 24, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas J. Devlin M.D., 20 Douglas Ave, Lonaconing, Md. 21539

31. Date filed (Month, Day, Year)

JAN 26 2011

32. Registrar's Signature

John R. Durst

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05964

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Philip Lloyd Welch, Jr.

2. Date of Death

February 8 2011

3. Time of Death

7:58 PM

4a. Facility Name (if not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

217-60-8809

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 20, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Port Tobacco

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8570 Port Tobacco Road

10f. Zip Code

20677

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Operator

16b. Kind of Business Industry

Power Plant

17. Father's Name (First, Middle, Last)

Philip Lloyd Welch, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Welch

19a. Informant's Name/Relationship (Type, Print)

Linda Welch/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8570 Port Tobacco Road, Port Tobacco, MD 20677

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery 2/11/2011

Date

20c. Location - City or Town, State

La Plata, MD

21. Signature of Funeral Service Licensee

David K. Echols

M00945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.

211 St. Mary's Ave. La Plata, MD 20646

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon cancer

Due to (or as a consequence of):

b. malignant Bilateral Pleural Effusions

Due to (or as a consequence of):

c. Lung metastasis

Due to (or as a consequence of):

d. Acute Respiratory Failure

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver metastasis, Chronic obstructive airway disease, Right hemicolectomy history, history chemotherapy, Diabetes Mellitus, Hypertension

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David K. Echols MD

29c. License number

D0008370

29d. Date signed (Month, Day, Year)

Feb 9, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL E. PRITCHETT, SR MD, P.O. Box 1317, 118 LAGANOS AV, LA PLATA, MD 20646

31. Date filed (Month, Day, Year)

FEB 11 2011

32. Registrar's Signature

Anna A. Jones

Welch Jr., Philip M264879  
Baltimore, Maryland 21215-0036To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

Amend#4b per MD, FCHD, 2/8/11, Certificate of Death LE

Reg. No.

2011 05965

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANE WAGNER

2. Date of Death

February 5 2011

3. Time of Death

7:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Copen Ridge

4b. City, Town, or Location of Death

Sinksville, MD 21784

4c. County of Death

Carroll

5. Social Security Number

218-21-9838

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

7/6/1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1105 North Main Street

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Organist

16b. Kind of Business/Industry

Calvary U. M. C.

17. Father's Name (First, Middle, Last)

Francis A. Conaway

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Bellison

19a. Informant's Name/Relationship (Type, Print)

Robert Wilson Wagner/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 North Main Street, Mt. Airy, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pine Grove Cemetery

Date

2/11/2011

20c. Location - City or Town, State

Mt. Airy, Maryland.

21. Signature of Funeral Service Licensee

Jodi D. Wagner

22. Name and Address of Facility

Stauffer Funeral Home P. A.  
1621 Opossumtown Pike, Frederick, MD 2170223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial infarction

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate  
Interval Between  
Onset and Death4 hours  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death  
4 ☐ Pregnant at time of death  
9 ☐ Unknown3 ☐ Ectopic pregnancy  
5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral  
dementia

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jodi D. Wagner MD

29c. License number

D34849

29d. Date signed (Month, Day, Year)

February 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Tan MD 1645 Liberty Rd E Idersburg MD 21784

31. Date filed (Month, Day, Year)

FEB 08 2011

32. Registrar's Signature

Denise S. Jones

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05966

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |  |
|---|---|--|---|---|--|--|--|--|
| Physician/<br>Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>AUDREY W WEAVER</b>  |  |   | 2. Date of Death<br>Month <b>February</b> Day <b>8</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>4:30 AM</b>   |  |  |
|   | 4a. Facility Name (if not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-14-7338</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 31, 1926</b>                          |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  |   | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Mt. Airy</b>   |  |  |
|   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |  |  |
|   | 10e. Street and Number<br><b>1131 Village Gate Drive</b>  |  |   | 10f. Zip Code<br><b>21771</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |   | 16b. Kind of Business Industry<br><b>Elementary Schools</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Stemple</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Wilson</b>  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda Dixon/ Daughter</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1131 Village Gate Drive, Mt. Airy, Maryland 21771</b> |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stauffer Crematory Inc.</b>  |   | 20c. Date<br><b>2/10/2011</b>  |  | 20d. Location - City or Town, State<br><b>Frederick, Maryland</b>                    |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes P. A.<br/>1621 Opossumtown Pike, Frederick, Maryland 21701</b>                              |  |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Septic Shock</b><br>a. Due to (or as a consequence of):<br><b>Pneumonia</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Hours</b><br><b>Hours</b> |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   |  | 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive Pulmonary Disease</b>  |   |  |   |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28d. Describe how injury occurred   |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> <b>MD</b>   |   |  | 29c. License number<br><b>MD51610</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>2/8/11</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. Tolino, 1475 Tawney Ave, Frederick, MD 21702</b>  |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

1- For State Registrar

Certificate of Death

Reg. No.

2011 05967

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Physician/  
Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Edward Westfall</b>  |  | 2. Date of Death<br>Month <b>02</b> Day <b>07</b> Year <b>2011</b>  |   | 3. Time of Death<br><b>0006 AM</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>Carroll Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |   | 4c. County of Death<br><b>Carroll</b>  |  |
| 5. Social Security Number<br><b>214-66-7328</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>08/26/1954</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                            |
| Usual Residence of Decedent  |  |   |   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Carroll</b>  | 10c. City, Town or Location<br><b>Hampstead</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>2311 New Mexico Road</b>  |  | 10f. Zip Code<br><b>21074</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Disabled</b>  |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Disabled</b>   |  | 16b. Kind of Business Industry<br><b>N/A</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Worthy Westfall</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Doka</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ricky Westfall/brother</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2104 Beverly Ct., Hampstead, MD 21074</b> |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation</b>  |   | 20c. Location - City or Town, State<br><b>02/09/2011 Hampstead, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>R. G. P. [Signature]</b>   |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home &amp; Chapel, PA<br/>412 Washington Road, Westminster, MD 21157</b>  |   |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hemorrhagic shock</b><br>Due to (or as a consequence of):<br><b>Gastric varices</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  | Approximate Interval Between Onset and Death<br><b>6 hours</b><br><b>unknown</b> |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Martin Britos Bray MD</b>  |  | 29c. License number<br><b>A 0064732</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>02 07 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Martin Britos Bray, Carroll Hospital Center, 200 Memorial Avenue</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760

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Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ETHEL WELDER</b>   |  | 2. Date of Death<br>Month <b>FEBRUARY</b> Day <b>4</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>2:00 P M</b>  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>7215 KENTOWN DRIVE</b>   |  | 4b. City, Town, or Location of Death<br><b>HYATTSVILLE</b>  |  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>  |  |
| 5. Social Security Number<br><b>232-60-3012</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  |
| 8. Date of Birth<br>(Month, Day, Year)<br><b>NOV. 2 1939</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>HYATTSVILLE</b>  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>7215 KENTOWN DRIVE</b>   |  | 10f. Zip Code<br><b>20785</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  | 16b. Kind of Business Industry<br><b>PRIVATE</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>RAYMOND MUTH</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDNA KRAMER</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CAROLYN SMITH/DGT</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9490 BLAKES ROAD LAPLATA, MARYLAND 20646</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD NATIONAL CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>2/9/2011 LAUREL, MARYLAND</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME, INC.<br/>7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785</b>  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC SMALL CELL LUNG CANCER</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown  |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  |
|   |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D37529</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>FEBRUARY 7, 2011</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RONALD WHEELER M.D., 1221 MERCANTILE LANE LARGO, MARYLAND 20774</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

5

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05969

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Francene L. Webb</b>  |  |   |  | 2. Date of Death<br>Month <b>January</b> Day <b>30</b> Year <b>2011</b>   |  |   |  | 3. Time of Death<br><b>10:00 a<sup>M</sup></b>   |  |  |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>7305 Old Branch Ave.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  |   |  | 4c. County of Death<br><b>Prince Georges</b>   |  |  |  |
| 5. Social Security Number<br><b>578-50-7080</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 18, 1936</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>                                |  |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Clinton</b>   |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>7305 Old Branch Ave.</b>  |  |   |  | 10f. Zip Code<br><b>20735</b>   |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pastor</b>  |  |   |  | 16b. Kind of Business Industry<br><b>Religious</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frances Brown</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Washington</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Isaac Webb / Spouse</b>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7305 Old Branch Ave. Clinton, Md. 20735</b> |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans</b>  |  | Date<br><b>2/9/2011</b>   |  | 20c. Location - City or Town, State<br><b>Cheltenham, Md.</b>                                      |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  |   |  | 22. Name and Address of Facility<br><b>Alexander S. Pope, P.A.<br/>5538 Marlboro Pike / Forestville, Md. 20747</b>                              |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Lung Cancer</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br><b>3.5 years</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>3 <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |  |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |  |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |  |   |  |   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |  |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  |   |  | 29c. License number<br><b>D0068056</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>2/3/2011</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elizabeth Pfaffenroth, MD 1221 Mercantile Lane, Largo, MD 20774</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 09 2011</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05970

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Billy Ernest Warnick Sr.

2. Date of Death  
Month Day Year

February 17, 2011

3. Time of Death  
A  
2:45M

4a. Facility Name (if not institution, give street and number)

623 Elm Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

219-44-1068

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

February 25, 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

623 Elm Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business Industry

Stone

17. Father's Name (First, Middle, Last)

Harry Warnick

18. Mother's Name (First, Middle, Maiden Surname)

Viola Matthews

19a. Informant's Name/Relationship (Type, Print)

Bonnie Warnick - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

623 Elm Street, Cumberland, Maryland, 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. View Cemetery

Date

February 22,  
2011

20c. Location - City or Town, State

Moscow Mills, Maryland

21. Signature of Funeral Service Licensee

► *Brandi Wilhelm*

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home P.A.  
8 East Main Street Lonaconing, MD 21539Physician/  
Medical  
Examiner23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *End stage Chronic Lung disease*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death  
*3+ yrs*Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *[Signature]*

29c. License number

D22181

29d. Date signed (Month, Day, Year)

February 17, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Garcy, Joannes MD 925 Bishop Walsh Drive, Cumberland, Maryland, 21502

31. Date filed (Month, Day, Year)

FEB 25 2011

32. Registrar's Signature

► *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No:

2011 05971

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN BOSLEY YELLOTT

2. Date of Death

Month Day Year  
FEBRUARY 16 2011

3. Time of Death

1:05 p<sup>M</sup>

4a. Facility Name (If not institution, give street and number)

31959 Virginia Lane

4b. City, Town, or Location of Death

Galena

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

213-28-9423

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

8. Date of Birth (Month, Day, Year)

March 4 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

Wellsville

10d. Inside City Limits

1 ☒ Yes ☐ No

10e. Street and Number

343 Main St.

10f. Zip Code

17365

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Hunting Guide

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Kinloch Nelson Yellott

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Bosley

19a. Informant's Name/Relationship (Type, Print)

John B. Yellott, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 East Market St. #4 Charlottesville, VA. 22902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Kent Cremation Service 2/17/11

Date

20c. Location - City or Town, State

Smyrna, DE.

21. Signature of Funeral Service Licensed

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen L. Schaech  
118 West Cross St. Galena, MD. 21635Approximate  
Interval Between  
Onset and Death  
6 weeks23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

a. Adenoma of colon

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN ; DM Type II ; Hypothyroid ;  
Hypercholesterolemia ; Hx Afib ; Vascular Dz ;  
Squamous Cell Mouth Cancer 1988 ; Basal Cell CA 1997

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hunting Lodge

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D0050996

29d. Date signed (Month, Day, Year)

2/17/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Stoddard, M.D. 100 Brown St. Chestertown, MD. 21620

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 25 2011

Neil B. Stoddard

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Lee Anthony

2. Date of Death

02 23 11

3. Time of Death

1:00 PM

4a. Facility Name (if not institution, give street and number)

Gilchrist Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

238-46-8422

6. Sex

1 X M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

8. Date of Birth

07/24/1930

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 X Yes 2 ☐ No

10e. Street and Number

2051 E. Belvedere Avenue

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 X Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 X No  
If Yes, Give  
Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business Industry

Transportation

17. Father's Name (First, Middle, Last)

Henry Anthony

18. Mother's Name (First, Middle, Maiden Surname)

Florine Bellamy

19a. Informant's Name/Relationship (Type, Print)

Geraldine C. Anthony Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2051 E. Belvedere Avenue Baltimore, Md. 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King Memorial

Date

3/4/2011

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Vaughn C. Greene F.S.

22. Name and Address of Facility

4905 York Road Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer, non small cell

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 X No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) hospice

27. Manner of Death

1 X Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

DS8303

February 23 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON J. CHARLES MD 6701 N Charles ST Towson MD

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Anna A. Jones

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05973

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Pearl M. Alston

2. Date of Death

February 20 2011

3. Time of Death

2:21 P M

4a. Facility Name (if not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

216-34-6478

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-24-1938

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5200 Bowleys Lane Apt 313

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeping

16b. Kind of Business Industry

University Hospital

17. Father's Name (First, Middle, Last)

Robert Branch

18. Mother's Name (First, Middle, Maiden Surname)

Julia Gilliam

19a. Informant's Name/Relationship (Type of relationship)

Keyarna M. Alston (Granddaughter)

9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3510 Carriage Hill Circle, Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium, or other place)

Jesus Cemetery

Date

2-28-2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

P. D. M01553

22. Name and Address of Facility

Vaughn O. Greene Funeral Services  
4905 York Rd. Balto MD 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INTRACRANIAL HEMORRHAGE

HYPERTENSION

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Blum H. WOLDENHUT

29c. License number

D0063327

29d. Date signed (Month, Day, Year)

Feb. 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIZAW W. WOLDENHUT, MD, 2324 W BELVEDER AVE, BALTIMORE, MD 21215

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Anna S. Parker

ALSTON, Pearl M.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05974

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernice Braxton

2. Date of Death

Month Day Year  
2-17-2011

3. Time of Death

6:04 a M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Ft. Washington Health and Reh. Center Fort Washington

4c. County of Death

Prince Georges

5. Social Security Number

579-14-7696

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

Month Day Year  
6-5-1917

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

DC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

508 Edgewood Street NE

10f. Zip Code

20018

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Afro American

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Clerical Worker

16b. Kind of Business Industry

CIA

17. Father's Name (First, Middle, Last)

Harry Mason

18. Mother's Name (First, Middle, Maiden Surname)

UNK

19a. Informant's Name/Relationship (Type, Print)

Michael Braxton/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7602 Redwood Ct. Brandywine MD 20613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harmony Memorial

Date

2-23-2011

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility John T. Rhines Funeral Home LLC

3005 12th Street NE Washington DC 20017

Physician/  
Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35206

29d. Date signed (Month, Day, Year)

February 18, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Tanner MD

11701 Livingston Road Fort Washington Maryland

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permitted. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Diane Banes Boulay

2. Date of Death

February 24, 2011

3. Time of Death

1:50 A M

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Gilchrist

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

217-92-8334

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

8. Date of Birth

4/4/1964

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

214 North Tyrone Road

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business Industry

Hospital

17. Father's Name (First, Middle, Last)

John W. Banes, III

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Delaney

19a. Informant's Name/Relationship (Type, Print)

Marc Boulay / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

214 North Tyrone Road Baltimore, Maryland 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Serv. Corp.

Date

3/1/2011

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic small cell bladder cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
14 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

venous thromboembolic disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58303

29d. Date signed (Month, Day, Year)

February 24 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON J. LAMAR MD 6701 N. CHARLES ST TOWSON MD

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1- For State Registrar

Certificate of Death

Reg. No. 2011 05976

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Percy L. Brown 2. Date of Death Month 2 Day 20 Year 2011 3. Time of Death 11:00 PM

Funeral  
Director

4a. Facility Name (if not institution, give street and number) Union Memorial Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death

5. Social Security Number 214-01-1427 6. Sex ☒ M ☐ F 7. Age (In yrs., last birthday) 92 Yrs. 8. Date of Birth (Month, Day, Year) 12-16-1918 9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent

10a. State MD 10b. County Baltimore 10c. City, Town or Location Owings Mills 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 12219 Garrison Forest Rd 10f. Zip Code 21117 10g. Citizen of What Country? USA

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Instructor 16b. Kind of Business Industry Transportation

17. Father's Name (First, Middle, Last) Jesse A. Brown 18. Mother's Name (First, Middle, Maiden Surname) Eva T. Roberts

19a. Informant's Name/Relationship (Type, Print) Robin Hillen Branch Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12219 Garrison Forest Road, Owings Mills, MD 21117

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Date 2-28-2011 20c. Location - City or Town, State Owings Mills, MD

21. Signature of Funeral Service Licensee Vaughn C. Greene 22. Name and Address of Facility Vaughn C. Greene Funeral Services 8728 Liberty Road, Randallstown, MD 21133

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Alzheimer's Dementia

23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia

23c. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Renal Failure

23d. Date of delivery Month Day Year

23e. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? ☐ Yes ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] MD 29c. License number D0064788 29d. Date signed (Month, Day, Year) 2/21/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY SHARMA 821 N. EUTAW ST. SUITE 301 BALTIMORE, MD 21201

31. Date filed (Month, Day, Year) FEB 28 2011 32. Registrar's Signature [Signature]

State Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05977

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Eunice Marie Boyce

2. Date of Death

2-21-2011

3. Time of Death

4:30 PM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

217-22-6743

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

9-21-1926

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9943 Hoyt Circle

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Masters Degree

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Educator

16b. Kind of Business Industry

Balto. City Schools

17. Father's Name (First, Middle, Last)

Harrison Alston

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Watson

19a. Informant's Name/Relationship (Type, Print)

Yvonne Fletcher (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9943 Hoyt Circle, Randallstown, MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King Memorial Park

Date

3-2-2011

20c. Location - City or Town, State

Balto. MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Vaughn T. Greene Funeral Services  
4905 York Rd. Balto MD 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Due to (or as a consequence of):

Dementia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ EP/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check

only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

D0069314

29d. Date signed (Month, Day, Year)

02/23/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal Prajapati 8813 Waltham Woods Rd Parkville MD 21234

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

[Signature]

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05978

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth Benas

2. Date of Death

February 24 2011

3. Time of Death

6:50 A M

4a. Facility Name (if not institution, give street and number)

6907 Chambers Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

29-62-6245

6. Sex

1 X M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10/08/1955

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 X No

10e. Street and Number

6907 Chambers Road

10f. Zip Code

21234

10g. Citizen of What Country?

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 X Divorced

12. Was Decedent Ever in U.S.

1 X Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Salesman

16b. Kind of Business Industry

Aquatic Company

17. Father's Name (First, Middle, Last)

L. James High

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Benas

19a. Informant's Name/Relationship (Type, Print)

Kevin Benas/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8409 Maymeadow Court Windsor Mill, MD 21244

20a. Method of Disposition

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Garrison Forest

Date

03/03/2011

20c. Location - City or Town, State

Dwings Mills, MD

21. Signature of Funeral Service Licensee

Vaughn C. Green

22. Name and Address of Facility

Vaughn C. Green Funeral Services

8728 Liberty Road Randallstown MD 21133

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No

25. Was case referred to medical examiner?

1 ☐ Yes 2 X No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N.S. Rajapakse, M.D.

29c. License number

00057465

29d. Date signed (Month, Day, Year)

2/25/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D. 2835 Smith Av S-203 Baltimore, MD 21209

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Diana B. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05979

1- For  
State  
Registrar

1. Decedent's Name (First, Middle, Last)

Khurshid Begum

2. Date of Death

Month Day Year  
02 26 2011

3. Time of Death

11:35A M

Physician/  
Medical  
Examiner

4a. Facility Name (if not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

569-85-0229

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 25, 1919

9. Birthplace (State or Foreign Country)

Pakistan

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1021 7th Street

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Asian

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Fazal Karim

18. Mother's Name (First, Middle, Maiden Surname)

Rabbia Bibi

19a. Informant's Name/Relationship (Type, Print)

Mansoor Zia/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1021 7th Street, Laurel, MD 20707

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Miami Saab

Date

3/7/2011

20c. Location - City or Town, State

Lahore, Pakistan

21. Signature of Funeral Service Licensee

[Signature]

M00770

22. Name and Address of Facility Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, MD 20707

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Failure to thrive

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Alzheimer's Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?  
1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism, Pacemaker status  
from positive Bacteremia, Hyperkalemia  
Chronic Kidney Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?  
1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?  
1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Karumwi M.D.

29c. License number

D68782

29d. Date signed (Month, Day, Year)

2/26/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adedeji Karumwi Laurel Regional Hospital Laurel MD 20707

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05980

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Chambers Jr

2. Date of Death

February 24 2011

3. Time of Death

02:35 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

240-36-6310

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 13, 1930

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5515 Stonington Ave

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Paul Chambers Sr

18. Mother's Name (First, Middle, Maiden Surname)

Roxie Perry

19a. Informant's Name/Relationship (Type, Print)

Wincy Chambers

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5515 Stonington Ave, Baltimore, MD 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial

Date

3/5/2011

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Beverly A. Howard

22. Name and Address of Facility

Howell Funeral Home 4600 Liberty Heights Ave, Balto MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC brain INJURY

Due to (or as a consequence of):

b. Hypoglycemia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 days

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Emilio, MD

29c. License number

D66130

29d. Date signed (Month, Day, Year)

February 24th, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA EMILIANO, MD SINAI HOSPITAL OF BALTIMORE

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Anna S. Jones

Patient known as CHAMBERS, PAUL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05981

1- For  
State  
RegistrarPhysician/  
Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Norman Carroll

2. Date of Death

February 26 2011

3. Time of Death

3:41 P M

4a. Facility Name (if not institution, give street and number)

Doctor's Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

5. Social Security Number

212-14-2868

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-17-1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13018 6th Street

10f. Zip Code

20720

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Boiler Engineer

16b. Kind of Business Industry

U.S.D.A.

17. Father's Name (First, Middle, Last)

James C. Carroll

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Susco

19a. Informant's Name/Relationship (Type, Print)

James E. Carroll Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7519 Lemon Tree Ct Hanover, MD 21076

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft Lincoln

Date

3/5/2011

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

D. Edgar Burch

22. Name and Address of Facility

Howell Funeral Home  
10220 Gwynford Road Jessup, MD 20794

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ Nog ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Cardiomyopathy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Alexander

29c. License number

D52815

29d. Date signed (Month, Day, Year)

2/26/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Daniel Alexander, 12700 Goodloes Promise Drive, Bowie, MD, 20720

31. Date filed (Month, Day, Year)

FEB 28 2011

Registrar's Signature

Kane A. Jones

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For  
State  
Registrar

## Certificate of Death

Reg. No. 2011 05982

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Curran

2. Date of Death

February 24 2011

3. Time of Death

2:15 P M

4a. Facility Name (if not institution, give street and number)

Arden Courts

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

032-20-0014

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 28, 1928

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8101 Bellona Ave.

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Colonel

16b. Kind of Business Industry

Air Force

17. Father's Name (First, Middle, Last)

Thomas Curran

18. Mother's Name (First, Middle, Maiden Surname)

Helen Pelletier

19a. Informant's Name/Relationship (Type, Print)

Mr. James Curran/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

243 Waxter Way Baltimore, MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Blue Hills Cemetery

Date

2-28-11

20c. Location - City or Town, State

Braintree, MA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, MD. 21204

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Dementia

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted living facility

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D58303

29d. Date signed (Month, Day, Year)

February 25 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amos J. Williams MD 6701 N. Charles ST Towson MD

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Dennis A. Parker

State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit







Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05984

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Helen Derus

2. Date of Death  
Month Day Year

February 21, 2011

3. Time of Death

11:00p M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Balto.

5. Social Security Number

216-14-7770

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

August 30, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Balto.

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7004 Connection Road

10f. Zip Code

21087

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Home

17. Father's Name (First, Middle, Last)

Vincent Wisniewski

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Sufczynski

19a. Informant's Name/Relationship (Type, Print)

Joan N. Trush

Dtr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7004 Connection Road Kingsville, Md. 21087

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus

Date

2-25-2011

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

B. A. Kelly

22. Name and Address of Facility

Schimunek Funeral Home  
9705 Belair Road Nottingham, Md. 21236

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of injury  
(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ernestine Wright

29c. License number

D 52740

29d. Date signed (Month, Day, Year)

February 22nd, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Ernestine B. Wright

State  
Registrar

11:00 P.M.  
Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JOAN DERUS  
FEBRUARY 21, 2011  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05985

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Douglas Dunn

2. Date of Death

Month February Day 26 Year 2011

3. Time of Death

8:30 AM

4a. Facility Name (if not institution, give street and number)

4214 Crest Place

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

218-27-4003

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

21 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 01-08-1990

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4214 Crest Place

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business Industry

Education

17. Father's Name (First, Middle, Last)

Jeffrey Harding Dunn

18. Mother's Name (First, Middle, Maiden Surname)

Jeannine A. Hooper

19a. Informant's Name/Relationship (Type, Print)

Jeffrey H. Dunn/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4214 Crest Place Ellicott City, MD 21043

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ardent Cremation Svc.

Date

02/28/2011

20c. Location - City or Town, State

Hanover, MD

21. Signature of Funeral Service Licensee

▶ *Sam Ellis*

M01044

22. Name and Address of Facility

Harry H. Witzke's Family FH Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Muscular dystrophy (Duchennes)*  
Due to (or as a consequence of): MUSCULAR DYSTROPHY (Duchennes)Approximate  
Interval Between  
Onset and Death  
approx 13  
yearsSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☐ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic illness (respiratory)*

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident Investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier

(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Michael W. May*

29c. License number

D0033975

29d. Date signed (Month, Day, Year)

02-28-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael W May 9501 Old Annapolis Rd Ste 101 Ellicott City, MD 21042

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

*Ann A. Park*State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05986

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Linda R. Dunmyer

2. Date of Death

Month Day Year  
FEBRUARY 25 2011

3. Time of Death

12:18 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BALTIMORE WASHINGTON MEDICAL CENTER

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

216-48-8080

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 23, 1947

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8451 Norwood Drive

10f. Zip Code

21108

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Hall

18. Mother's Name (First, Middle, Maiden Surname)

Rucker

19. Informant's Name/Relationship (Type, Print)

Elisabeth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Wimmer

19a. Informant's Name/Relationship (Type, Print)

Robert R. Dunmyer (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1508 Marco Drive Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Mem. Pk.

Date

03/01/11

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.A.

3204 Mountain Road Pasadena, Maryland 21122

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

a. Due to (or as a consequence of):

PNEUMONIA

b. Due to (or as a consequence of):

LUNG CANCER

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☒ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an

autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available

prior to completion of cause of

death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending2 ☐ Accident 6 ☐ Investigation3 ☐ Suicide 6 ☐ Could not be4 ☐ Homicide 6 ☐ determined

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

M

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check

only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

J0053703

29d. Date signed (Month, Day, Year)

FEBRUARY 25, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 Hospital Dr Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DUNMYER, LINDA R.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05987

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Alvin Engelhardt

2. Date of Death

February 25, 2011

3. Time of Death

3:44 PM

4a. Facility Name (if not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

293-09-0346

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days Hours Min.

If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 18, 1916

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

113 West Lake Avenue

10f. Zip Code

21210

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business Industry

Aerospace

17. Father's Name (First, Middle, Last)

Alvin Herman Engelhardt

18. Mother's Name (First, Middle, Maiden Surname)

Emma Tomaszewski

19a. Informant's Name/Relationship (Type, Print)

Kelly A. Krumpke (Personal Rep.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

409 Washington Ave. Suite 314 Towson, MD 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Grns. Maus. 3-2-11

Date

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Joseph Fennema

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmia

b. Coronary artery disease

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 ☒ None2 ☐ 1-24 hrs3 ☐ 1-7 days4 ☐ 8-30 days5 ☐ 1-3 months6 ☐ 3-12 months7 ☐ 1-5 years8 ☐ 6-12 years9 ☐ 13-17 years10 ☐ 18-24 years11 ☐ 25-34 years12 ☐ 35-44 years13 ☐ 45-54 years14 ☐ 55-64 years15 ☐ 65-74 years16 ☐ 75-84 years17 ☐ 85-94 years18 ☐ 95 years and over

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anemia  
hypothyroidism

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD [FJ Townsend III]

29c. License number

D27117

29d. Date signed (Month, Day, Year)

2/26/2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francis James Townsend, III

6701 N. Charles St. Towson, MD 21204

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Angela B. Parker

State  
RegistrarEngelhardt, Richard  
Baltimore, Maryland 21215-0036permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05988

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annette Marie Eckart

2. Date of Death

Month Day Year  
February 25, 2011

3. Time of Death

7:55A. M

4a. Facility Name (if not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Balto.

Funeral  
Director

5. Social Security Number

214-26-6841

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 20, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Balto.

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Troon Court

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Home

17. Father's Name (First, Middle, Last)

Ben Brocato

18. Mother's Name (First, Middle, Maiden Surname)

Rose Brocato

19a. Informant's Name/Relationship (Type, Print)

Donald L. Eckart, Jr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

83 Hilltop Road Delta, Pa. 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

3-1-2011

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Home Licensee



22. Name and Address of Facility

Schimunek Funeral Home

9705 Belair Road Nottingham, Md. 21236

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (Specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☒ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

R127474

29d. Date signed (Month, Day, Year)

2/25/11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUNECIA WHITE, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature


State  
Registrar

FEBRUARY 25, 2011 7:55 a.m.

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To Be Completed by Physician/Medical Examiner

ANNETTE ECKART  
Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05989

1- For  
State  
RegistrarPhysician  
/Medical  
Examiner

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Rae Lynn Fisher</b>   |  | 2. Date of Death<br>Month <b>February</b> Day <b>26</b> Year <b>2011</b>   |  | 3. Time of Death<br><b>3:50 A M</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>6815 East Brook Ave.</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>  |  |
| 5. Social Security Number<br><b>213-68-9423</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>August 17 1957</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>   |  |   |  |
| Usual Residence of Decedent  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>6815 East Brook Ave</b>   |  | 10f. Zip Code<br><b>21224</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>NA</b>            |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Wife</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>HERMAN Rehbiem</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth MORRIS</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark A. Hudson (Husband)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6815 East Brook Baltimore, Maryland 21224</b> |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bayview Crematory, Inc.</b>   |  | 20c. Date<br><b>March 1, 2011</b>   |  |
| 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Mark A. Hudson</b>   |  | 22. Name and Address of Facility<br><b>W. Dabrowski &amp; Chomacki Funeral Home PA 1005 Dundalk Ave. Baltimore, Maryland</b>                      |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Leiomyosarcoma</b>   |  |  |  |   |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Metastatic Leiomyosarcoma</b>  |  |  |  |   |  |
| 23c. If yes, outcome of pregnancy<br><input type="checkbox"/> Live birth <input type="checkbox"/> Fetal death <input type="checkbox"/> Ectopic pregnancy<br><input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Other (specify) _____  |  |  |  |   |  |
| 23d. Date of delivery<br>Month _____ Day _____ Year _____  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |
| 23e. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  |   |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>March 1, 2011</b>   |  |  |  |   |  |
| 28b. Time of Injury<br><b>M</b>  |  |  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 28d. Describe how injury occurred  |  |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Alan White MD</b>  |  |  |  |   |  |
| 29c. License number<br><b>041614</b>   |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>February 28 2011</b>   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alan White 4920 Campbell Blvd Baltimore, MD 21236</b>   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2011</b>  |  |  |  |   |  |
| 32. Registrar's Signature<br><b>Donna J. Jones</b>   |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 2011 05000

1- For  
State  
RegistrarPhysician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirrell Johnson Garrison

2. Date of Death

February 23 2011

3. Time of Death

5:30 AM

Funeral  
Director

4a. Facility Name (if not institution, give street and number)

Hospice of the Chesapeake

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

A. A

5. Social Security Number

214-52-8496

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 4, 1953

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

250 Thompson Ave

10f. Zip Code

21060

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Banker

16b. Kind of Business Industry

Banking

17. Father's Name (First, Middle, Last)

Samuel Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Crawford

19a. Informant's Name/Relationship (Type, Print)

Lisa Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

250 Thompson Ave, Glen Burnie, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest

Date

3/3/2011

20c. Location - City or Town, State

Dwings Mills, MD

21. Signature of Funeral Service Licensee

Dwight H. H. H.

22. Name and Address of Facility

Howell Funeral Home  
4600 Liberty Heights Ave, Balto. MD 2120723a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Due to (or as a consequence of):  
No testicular Cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

IF FEMALE:

23b. Was decedent pregnant  
in the past 12 months?1 ☐ Yes 2 ☒ No  
9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an  
autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings available  
prior to completion of cause of  
death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)Hospice  
House

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check  
only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dwight H. H. H.

29c. License number

031557

29d. Date signed (Month, Day, Year)

February 25, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell J. Deluca MD, 305 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Anne B. Jones

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

State  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05991

1- For  
State  
Registrar

|  |   |  |   |   |  |   |   |  |  |  |
|--|---|--|---|---|--|---|---|--|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Patsy D. Ginsberg   |  |   |   |  |   | 2. Date of Death<br>Month: February Day: 25 Year: 2011  |  | 3. Time of Death<br>9:05P M  |  |
|  | 4a. Facility Name (if not institution, give street and number)<br>BALTIMORE WASHINGTON MEDICAL CENTER   |  |   |   |  |   | 4b. City, Town, or Location of Death<br>Glen Burnie     |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-28-9194  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>78 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Jan. 08 1933     |  | 9. Birthplace (State or Foreign Country)<br>PA   |  |
|  | Usual Residence of Decedent   |  |   |   |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |  | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Glen Burnie   |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>540 Elizabeth Lane  |  |   |   | 10f. Zip Code<br>21060   |   | 10g. Citizen of What Country?<br>USA                    |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates. |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waitress  |   |   | 16b. Kind of Business Industry<br>Restaurant                     |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Bert A. Dull   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie R. Moon  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Brenda Koenig (daughter)  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>907 220th Street, Pasadena, MD 21122 |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery |  |   | Date<br>March 05 2011                                   |  | 20c. Location - City or Town, State<br>Quincy Township, PA   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |   |  | 22. Name and Address of Facility<br>Stallings Funeral Home, P.A.<br>3111 Mountain Road, Pasadena, MD 21122                            |   |  |  |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>RESPIRATORY FAILURE</u><br>Due to (or as a consequence of):<br>b. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>Due to (or as a consequence of):<br>c. <u>RENAL FAILURE</u><br>Due to (or as a consequence of):<br>d. _____ |  |   |   |  |   |   |  |  |  |
|  | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Unknown   |  |   |   |  |   |   |  |  |  |
| 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) _____  |   |  |   |   |  |   |   |  |  |  |
| 23d. Date of delivery<br>Month Day Year  |   |  |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |  |   |   |  |  |  |
| 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |   |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |   |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |   |  |   |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |   |   |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |  |   |   |  |   |   |  |  |  |
| 28a. Date of injury (Month, Day, Year)   |   |  | 28b. Time of injury<br>M  |   | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                       |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |   |   |  |  |  |
| 29b. Signature and Title of certifier<br>  |   |  |   |   | 29c. License number<br>D 45149   |   | 29d. Date signed (Month, Day, Year)<br>February 25 2011 |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ONABAYD 301 Hospital drive Glen Burnie MD 20161  |   |  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>FEB 28 2011   |   |  |   |   |  |   |   |  |  |  |
| 32. Registrar's Signature<br>  |   |  |   |   |  |   |   |  |  |  |

CHMS REG. PATSY  
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05992

## 1- For State Registrar

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |
|---|--|--|---|---|--|
| Physician/<br>Medical Examiner                | 1. Decedent's Name (First, Middle, Last)<br>William H. Gully, <del>III</del> III   |  | 2. Date of Death<br>Month Day Year<br>February 24, 2011   |   | 3. Time of Death<br>0849 hrs   |
|   | 4a. Facility Name (if not institution, give street and number)<br>Harbor Hospital Center   |  | 4b. City, Town, or Location of Death<br>Baltimore   |   | 4c. County of Death  |
| Funeral Director                              | 5. Social Security Number  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>29 Yrs.   | 8. Date of Birth (MM/DD/YYYY)<br>10/24/81 | 9. Birthplace (State or Foreign Country)<br>MD   |
|   | Usual Residence of Decedent  |  |   |   |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD   | 10b. County<br>N/A   | 10c. City, Town or Location<br>Baltimore  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br>1607 Harden Ct   |  | 10f. Zip Code<br>21230  | 10g. Citizen of What Country?<br>USA      |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>White  |  | Specify:  |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Welder   |   | 16b. Kind of Business/Industry<br>Manufacturing  |
|   | 17. Father's Name (First, Middle, Last)<br>William H. Gully, Jr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Joann Jackson  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Joann Jackson/Mother   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>31 Ruth Avenue, Laurel MD 20723  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other Specify:   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ardent Crematory  |   | 20c. Location - City or Town, State<br>Hanover Maryland  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Victor Doda   |  | 22. Name and Address of Facility<br>Charles L. Stevens Funeral Home, Inc.<br>1501 E. Fort Avenue, Baltimore MD 21230  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) a. <u>Oxycodone Intoxication</u><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. <u>1, 23a, 27, 28a-f, per me g916 6-20-11 vt</u><br>d. <u>I per me g916 6-24-11 vt</u><br><input checked="" type="checkbox"/> UNPENDED <input checked="" type="checkbox"/> AMENDED |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (Specify)<br>9 <input type="checkbox"/> Unknown |   | 23d. Date of delivery<br>Month Day Year  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other:          |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>fd 2-24-11  |   | 28b. Time of Injury<br>fd 7:30am   |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>subject ingested oxycodone   |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>residence  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1607 Hardens Ct. Baltimore, Md. 21230   |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>Russell Alexander MD. Assistant Medical Examiner  |  | 29c. License number<br>O.C.M.E.   |   | 29d. Date signed (Month, Day, Year)<br>February 25, 2011   |
|   | 30. Name and address of person who completed cause of death (Item 23a)<br>Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  |  |   |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>FEB 28 2011   |  | 32. Registrar's Signature<br>Anna S. Gault  |   |  |

Baltimore, MD 21215-0036

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05993

1- For  
State  
Registrar

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/  
Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

|   |   |   |  |  |
|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><i>Peter John Golueke MD</i>  |   | 2. Date of Death<br>Month <i>2</i> Day <i>21</i> Year <i>2011</i>   |  | 3. Time of Death<br><i>4:34 PM</i>   |
| 4a. Facility Name (if not institution, give street and number)<br><i>3811 Hadley Square East</i>  |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><i>None</i>   |
| 5. Social Security Number<br><i>217-62-5572</i>   | 6. Sex<br><i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>55</i> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><i>08/17/1955</i> |  |
| 9. Birthplace (State or Foreign Country)<br><i>Wisconsin</i>  |   | 10. Usual Residence of Decedent   |  |  |
| 10a. State<br><i>Maryland</i>   | 10b. County<br><i>None</i>  | 10c. City, Town or Location<br><i>Baltimore</i>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><i>3811 Hadley Square East</i>  |   | 10f. Zip Code<br><i>21218</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>  |
| 11. Marital Status<br><i>2</i> <input checked="" type="checkbox"/> Married<br><i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |   | 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i> <i>College (1-4 or 5+)</i> <i>5+</i>  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Physician</i>   |   | 16b. Kind of Business Industry<br><i>Medical</i>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Joseph Louis Golueke</i>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Florence Marie Perrigoue</i>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Valerie Sentz Golueke</i>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>Wife 3811 Hadley Square East Baltimore, Maryland 21218</i>  |  |  |
| 20a. Method of Disposition<br><i>2</i> <input checked="" type="checkbox"/> Burial <i>3</i> <input type="checkbox"/> Cremation <i>4</i> <input type="checkbox"/> Removal from State<br><i>5</i> <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>GreenMount Crematory</i>   |  | 20c. Location - City or Town, State<br><i>02/23/2011 Baltimore, Maryland</i>   |
| 21. Signature of Funeral Service Licensee<br><i>James H. Harkins</i>  |   | 22. Name and Address of Family<br><i>Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212</i>  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. malignant glioblastoma, brain</i>   |   | 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  | Approximate Interval Between Onset and Death<br><i>2 years</i>   |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No  |   | 23c. If yes, outcome of pregnancy<br><i>1</i> <input type="checkbox"/> Live Birth <i>2</i> <input type="checkbox"/> Fetal death <i>3</i> <input type="checkbox"/> Ectopic pregnancy<br><i>4</i> <input type="checkbox"/> Pregnant at time of death <i>5</i> <input type="checkbox"/> Other (specify)  |  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23e. Did tobacco use contribute to the cause of death?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No <i>3</i> <input type="checkbox"/> Probably <i>4</i> <input type="checkbox"/> Unknown  |  |  |
| 24a. Was an autopsy performed?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DDA Other: <i>4</i> <input type="checkbox"/> Nursing Home <i>5</i> <input checked="" type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify)   |  |  |
| 27. Manner of Death<br><i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation<br><i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined<br><i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |
| 28c. Injury at work?<br><i>1</i> <input type="checkbox"/> Yes <i>2</i> <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><i>1</i> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>3</i> <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Thomas F. Lansdale MD</i>   |  | 29c. License number<br><i>D 43936</i>  |
| 29d. Date signed (Month, Day, Year)<br><i>2/21/11</i>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Thomas F. Lansdale III MD 6535 N. Charles St. Baltimore MD 21204</i>   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>FEB 28 2011</i>   |   | 32. Registrar's Signature<br><i>James B. Spivey</i>   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

1- For  
State  
Registrar

Reg. No. 2011 05894

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lula L Grace

2. Date of Death

Feb 21 2011

3. Time of Death

4:28 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center Baltimore MD

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

213-34-7632

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

72

8. Date of Birth

08-13-1938

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

-----

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3026 Janice Avenue

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business Industry

Own Home

17. Father's Name (First, Middle, Last)

Dom Batze

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Helen Sieg

19a. Informant's Name/Relationship (Type, Print)

Daniel J. Grace - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12289 Greensboro Rd., Greensboro, MD 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Prk.

Date

02-25-2011

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

Mark H. Brennan

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra cerebral Hemorrhage

Due to (or as a consequence of):

b. Warfarin therapy

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Bond

29c. License number

D60754

29d. Date signed (Month, Day, Year)

Feb 22, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Bond, MD 22 S. Greene St. Baltimore MD 21201

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Lula L. Grace

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05995

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen Harron

2. Date of Death

Month Day Year  
February 27 2011

3. Time of Death

02:10 AM

4a. Facility Name (If not institution, give street and number)

Futurecare Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-12-9915

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 22 1922

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

223 McKinsey Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Household

17. Father's Name (First, Middle, Last)

Richard A. Knight

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Norgran

19a. Informant's Name/Relationship (Type, Print)

Beverly Golaboski (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

223 McKinsey Road, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

March 02

2011

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Beverly Golaboski

22. Name and Address of Facility

Stallings Funeral Home, P.A.

3111 Mountain Road, Pasadena, MD 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☒ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

progressive supranuclear palsy

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jennifer Riedinger MD

29c. License number

J50725

29d. Date signed (Month, Day, Year)

2-28-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Riedinger 8601 Veterans Hwy Millersville, MD 21108

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Kathleen A. Spence

State  
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2011 05996

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician/  
Medical Examiner1- For State  
Registrar1. Decedent's Name (First, Middle, Last)  
*John William Hall*2. Date of Death  
Month Day Year  
January 28, 20113. Time of Death  
0928 hrs4a. Facility Name (if not institution, give street and number)  
Harford Memorial Hospital4b. City, Town, or Location of Death  
Havre de Grace4c. County of Death  
HarfordFuneral  
Director5. Social Security Number  
218-06-23506. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
26 Yrs.If Under 1 Year  
Months Days Hours Min.8. Date of Birth (MM/DD/YYYY)  
07/06/19849. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Harford10c. City, Town or Location  
Aberdeen10d. Inside City Limits  
1 ☐ Yes 2 ☒ No10e. Street and Number  
1 West Aztec Street10f. Zip Code  
2100110g. Citizen of What Country?  
United States of America11. Marital Status  
1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No specify:14. Race - American Indian, Black,  
White, etc.  
Specify: White15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 9  
College (1-4 or 5+)16a. Decedent's Usual Occupation (Give kind of work done  
during most of working life. DO NOT use retired)  
Brick Layer16b. Kind of Business/Industry  
Masonry17. Father's Name (First, Middle, Last)  
Loenard Carl Hall, 1118. Mother's Name (First, Middle, Maiden Surname)  
Leslie Ferguson19a. Informant's Name/Relationship (Type, Print)  
Leslie Weitherow (mother)19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
124 West Aztec Street, Aberdeen, Maryland 2100120a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other Specify:20b. Place of Disposition (Name of cemetery,  
crematory or other place)  
Harford Memorial GdnsDate  
02-04-201120c. Location - City or Town, State  
Aberdeen, Maryland

Signature of Funeral Service Licensee

*Tana C. Zedman*

22. Name and Address of Facility

123 S. Washington St. Havre de Grace, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Mixed drug (Methadone, oxycodone, and alprazolam)  
Due to (or as a consequence of): intoxication

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

☒ UNPENDED☐ AMENDED  
23a, 27, 28a-f, per M E g913 3/3/11 TTIF FEMALE:  
23b. Was decedent pregnant in the past 12 months?  
1 ☐ Yes 2 ☐ No 9 ☐ Unknown23c. If yes, outcome of pregnancy  
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  
4 ☐ Pregnant at time of death 5 ☐ Other (Specify)  
9 ☐ Unknown23d. Date of delivery  
Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy performed?  
1 ☒ Yes 2 ☐ No24b. Were autopsy findings available prior to completion of cause of death?  
1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other:27. Manner of Death  
1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☒ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury (Month, Day, Year)  
fd 1/28/1128b. Time of Injury  
fd 8:56 am28c. Injury at Work?  
1 ☐ Yes 2 ☒ No28d. Describe how injury occurred  
unk28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
found in house28f. Location (Street and Number or Rural Route Number, City or Town, State)  
1306 Halls Rd  
Havre de Grace, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 29, 2011

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

*[Signature]*State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, MD 21215-0036  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 909C.Physician/  
Medical ExaminerDivision of Vital Records, P.O. Box 68760,  
Baltimore, MD 21268-7600  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit certificate.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

2011 05997

1- For  
State  
RegistrarPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Harry

Happoldt

2. Date of Death

February 23, 2011

3. Time of Death

02:21 AM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

257-48-9411

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

8. Date of Birth

03/02/1934

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2925 DILLON STREET

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

1952-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCKER

16b. Kind of Business/Industry

GROUND FREIGHT

17. Father's Name (First, Middle, Last)

WILLIE CHARLES HAPPOLDT

18. Mother's Name (First, Middle, Maiden Surname)

CLARA WARD BRYANT

19a. Informant's Name/Relationship (Type, Print)

GLADYS HAPPOLDT/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2925 DILLON STREET, BALTIMORE, MD. 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK LAWN CEMETERY

Date

2/26/11

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME  
1901 EASTERN AVENUE, BALTIMORE, MD 21231

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple organ system failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MRSA pneumonia with bacteremia

Due to (or as a consequence of):

10 days

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No9 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death4 ☐ Pregnant at time of death9 ☐ Unknown3 ☐ Ectopic pregnancy5 ☐ Other (specify)

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

240744

29d. Date signed (Month, Day, Year)

February 23, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.A. Kozicki, MD Mercy Medical Center

345 St. Paul Place Baltimore, MD 21201

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05998

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Editha Iturralde Inserto

2. Date of Death

Feb - 22 - 2011

3. Time of Death

4:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Courtland Gardens

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

5. Social Security Number

217-98-5722

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 10, 1920

9. Birthplace (State or Foreign

Country)

Philippines

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Woodstock

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10222 Harvest Fields Drive

10f. Zip Code

21163

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Philippino

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Clerk

16b. Kind of Business Industry

Hospital

17. Father's Name (First, Middle, Last)

Faustino Iturralde

18. Mother's Name (First, Middle, Maiden Surname)

Hegina Ituriga

19a. Informant's Name/Relationship (Type, Print)

Apollo Iturralde Inserto

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10222 Harvest Fields, Woodstock, Maryland 21163

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

3-5-11

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael P. Marzullo

22. Name and Address of Facility

Marzullo Funeral Chapel, P.A.

6009 Harford Road, Baltimore, Maryland 21214

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Approximate Interval Between Onset and Death

&lt; 30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebral vascular accident

7 1/2 years

c. Hypertension

7 1/2 years

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months?

1 ☐ Yes 2 ☐ No3 ☐ Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy4 ☐ Pregnant at time of death 5 ☐ Other (specify)6 ☐ Unknown

23d. Date of delivery

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Ryan

29c. License number

B44817

29d. Date signed (Month, Day, Year)

Feb. 22 - 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Ryan 2434 W. Scherene Ave Baltimore MD 21211

State  
Registrar

31. Date filed (Month, Day, Year)

FEB 28 2011

32. Registrar's Signature

B. Sparks

Division of Vital Records, P.O. Box 68760

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 05999

1- For  
State  
Registrar

## Certificate of Death

Reg. No.

Physician/  
Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Doris Violet Johns</b>  |  | 2. Date of Death<br>Month <b>02</b> Day <b>24</b> Year <b>2011</b>  |  | 3. Time of Death<br><b>22:31 M</b>   |  |
| 4a. Facility Name (if not institution, give street and number)<br><b>University of Maryland Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death  |  |
| 5. Social Security Number<br><b>217-12-6328</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>07/03/1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>6668 Roberts Court</b>  |  | 10f. Zip Code<br><b>21061</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Server</b>  |  | 16b. Kind of Business Industry<br><b>Restaurant</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Fredrick Schmuff</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Flag Kine</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Johns / Grandson</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5303 Brookwood Rd., Brooklyn, MD 21225</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>W. Arundel Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Odenton, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Mal E. R...</b>  |  | 22. Name and Address of Facility<br><b>Bailey Funeral Home and Cremation Service, PA<br/>4023 Annapolis Rd., Halethorpe, MD 21227</b>   |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Alzheimer's disease</b>   |  | a. Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  | b. Due to (or as a consequence of):   |  |  |  |
|  |  | c. Due to (or as a consequence of):   |  |  |  |
|  |  | d. Due to (or as a consequence of):   |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown   |  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)<br>9 <input type="checkbox"/> Unknown |  | 23d. Date of delivery<br>Month Day Year  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23e. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  |
| 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>MD</b>   |  | 29c. License number<br><b>1962121420</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>2/24/11</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Tina Gupta, 22 S. Greene St., Baltimore, MD 21201</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2011</b>  |  | 32. Registrar's Signature<br><b>James D. Spake</b>  |  |  |  |

To Be Completed by Funeral Director

Medical Certificate: To Be Completed by Physician/Medical Examiner

Physician/  
Medical  
ExaminerState  
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
 1- For State Registrar Amend Item 23a per dr., g913, 03/07/2011  
 Certificate of Death  
 Reg. No. 2011 06000

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| Physician/<br>Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Walter S. Koski</b>   |  | 2. Date of Death<br>Month Day Year<br><b>FEBRUARY 26, 2011</b>  |  | 3. Time of Death<br><b>6:40A M</b>   |
|  | 4a. Facility Name (if not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-03-9271</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 2, 1913</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Towson</b>   |
|  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |
|  | 10e. Street and Number<br><b>809 E. Seminary Avenue</b>  |  | 10f. Zip Code<br><b>21286</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Professor of Chemistry</b>  |  | 16b. Kind of Business Industry<br><b>Johns Hopkins University</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Braun Stankewicz</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Laskowska</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol L. Koski / daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1300 Hummingbird Court; Santa Fe, NM 87501</b>  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | 20c. Location - City or Town, State<br><b>3/1/2011 Towson, MD</b>  |
|  | 21. Signature of Funeral Director<br>  |  | 22. Name and Address of Facility<br><b>1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204</b>   |  |  |
| Physician/<br>Medical<br>Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>ASPIRATION PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>DYSPHASIA DYSPHAGIA</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>DEMENTIA</b><br>Due to (or as a consequence of):                   |  |   |  | Approximate Interval Between Onset and Death<br><b>DAYS</b><br><b>YEARS - MONTHS</b><br><b>YEARS</b>   |
|  | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown   |  |   |  | 23c. Date of delivery<br>Month Day Year  |
|  | 23c. If yes, outcome of pregnancy<br>1 <input type="checkbox"/> Live Birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy<br>4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23d. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)<br><b>M</b>  |  | 28b. Time of injury<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |
|  | 28c. Describe how injury occurred  |  | 28d. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 61731</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>2/26/2011</b>    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>REGINA GAN-CARDEN, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b> |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>FEB 28 2011</b>  |  | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760